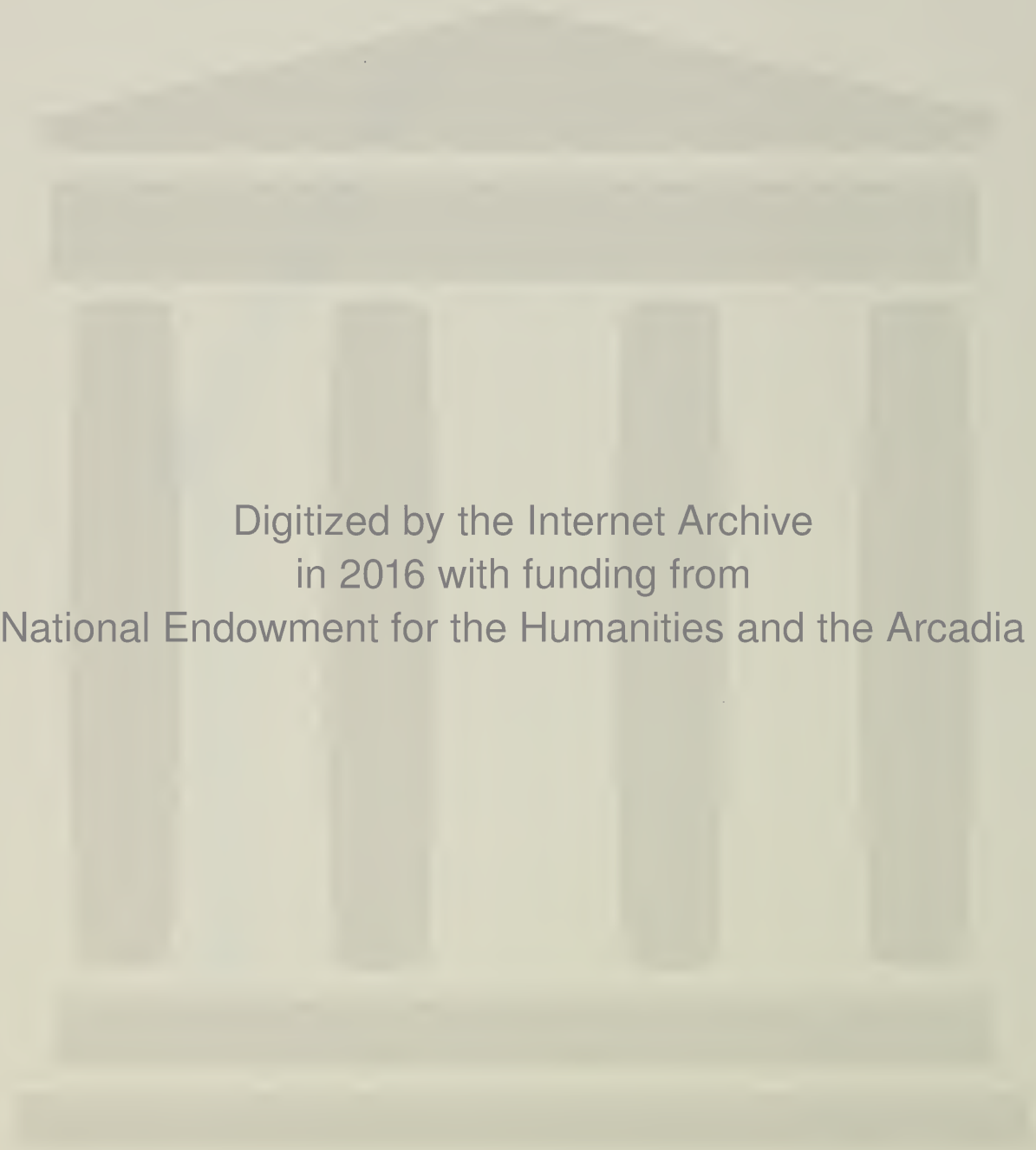
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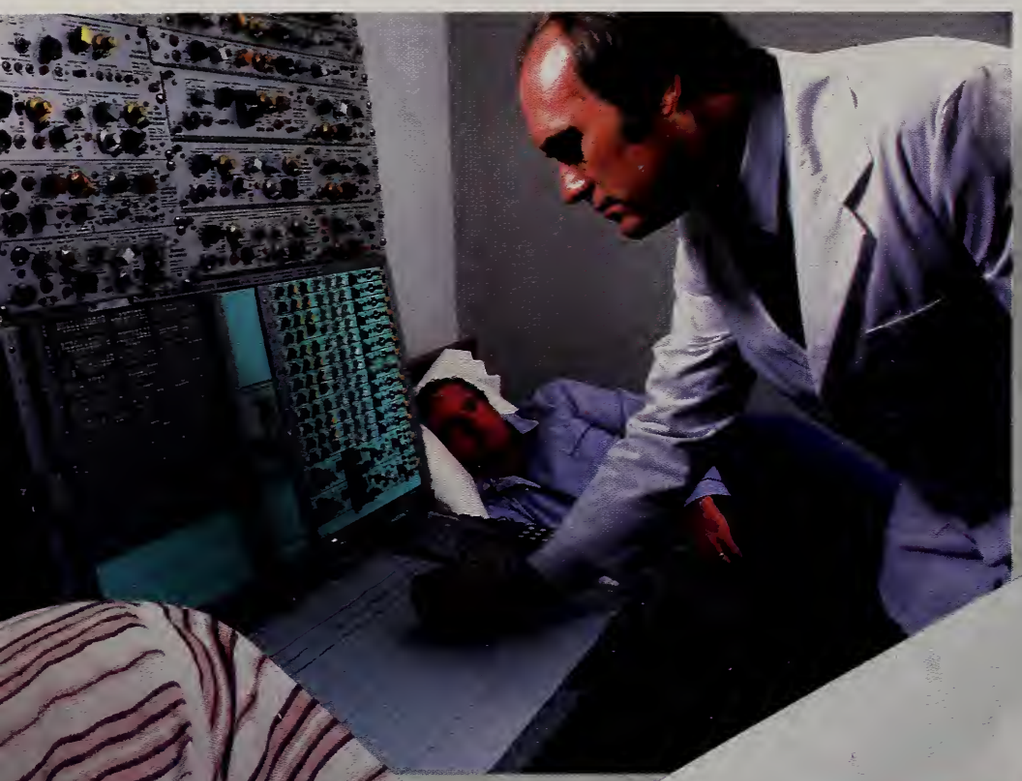
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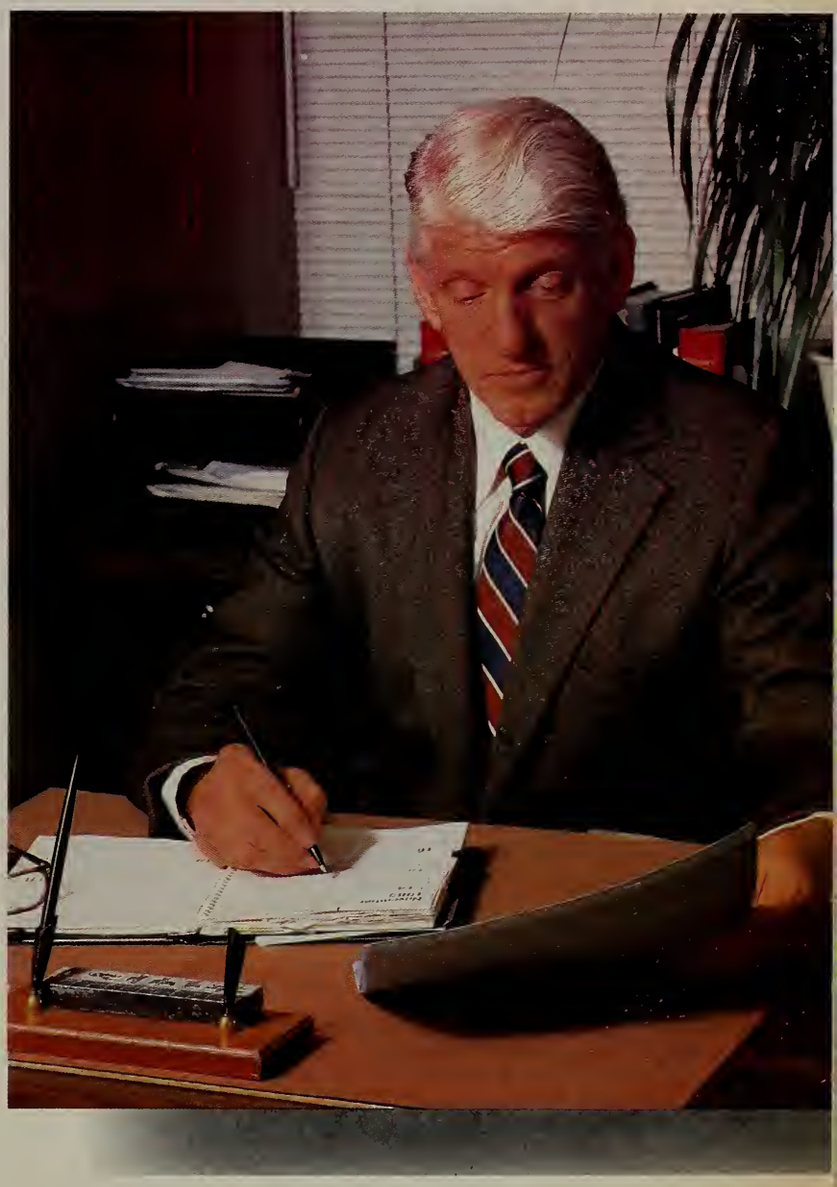
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Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1983 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

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Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

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THE Ohio STATE Medical Journal
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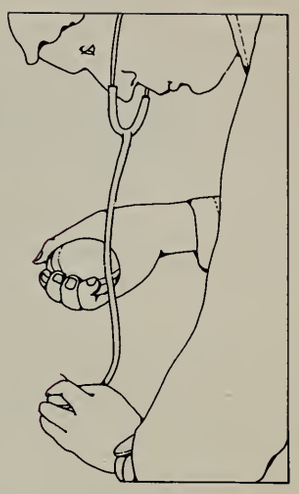
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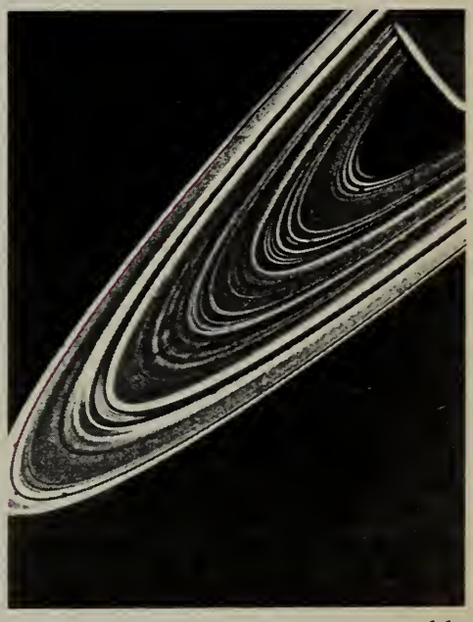
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A Challenge

By S. Baird Pfahl, Jr., MD

As the new year begins, it is the time we traditionally review the year past and plan for the future.

Our year, 1983, has been successful from a legislative standpoint; but as is often said, "You can't win 'em all" — and we didn't. Our legislative staff (Federal and State) numbers just five, but they monitor, investigate, testify, research, suggest possible legislation, follow the rule-making bodies and much more. Our staff follows up to 150 pieces of legislation at the statehouse each session and even more at the federal level. How they find the stamina, I don't know but I am grateful that they are able to accomplish so much for our organization.

Proposed state legislation is evaluated by our staff and then referred to the state legislation committee, chaired by Ben Reed of Delta. The committee then reviews the legislation and presents its findings to Council where the decision to support, not to support, no position, etc. is made. Our staff then goes back to the statehouse to inform the legislators of our views and suggestions (some might even call it lobbying) and then await the vote results and hopefully have a small victory "celebration" before the next vote.

The OSMA Federal Legislative department is headed by Brent Mulgrew who also serves as Director of OSMA's Department of Legal Services. Eric Burkland is head of state legislation and is assisted by Mike Bateson and Aris Hutras, with Cathy Costello, of the Department of Legal Services, specializing in the state boards and rule-making functions. They all do a super job but do we really need them? The answer to that question is an unqualified — YES. We need them because a large percentage of our membership does not know who their elected representatives are nor how to contact them.

Medicine, as we know it, is at, or perhaps past, the crossroads and our future method of practice will be determined in Columbus and Washington and not in our offices. Physicians, in general, have been too complacent to make the effort to "get involved" politically.

I feel there are four levels of political involvement. The first is to do nothing and then "bitch" about the results. The next level is to join OMPAC — at least you commit some money and see some involvement but only 14% do even that. A more effective level is that of campaign or precinct worker, local contributor, etc. — a most worthwhile status. My highest level of political involvement is to know personally, work hard for, contribute significantly to a legislator or candidate. This takes a significant commitment of money, talent and your most valuable asset — TIME. And time, my fellow physicians, is running out for us.

This then leads me to the title of this piece — A Challenge. I challenge each one of you to attain one of the three upper levels of political involvement noted above — move up one level from where you are — unless you are one of the few at the "top" level. Our effectiveness in the next few years depends upon your actions and we all want those who follow us in medicine to enjoy it as much as we do.

I hope your holidays were happy and I wish all of you a pleasant and healthy New Year and further hope you accept my challenge. **OSMA**

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Letters to the editor

Project Health Care in Richland

To the Editor:

I would like to compliment you on the excellent article in the November issue of *The Ohio State Medical Journal* with regard to health care for the unemployed. It is indeed heartening to read about the many medical communities and individual physicians who are concerned enough to accept responsibility for the physical and mental well-being of the indigent.

However, we were dismayed to find that our own program, PROJECT HEALTH CARE, under the sponsorship of the Richland County Medical Society, was not included. We are sure that this is due, at least in some part, to our failure to adequately inform you of our efforts in this respect.

The Richland County Medical Society, concerned with the double-digit unemployment in Richland County, sought to find ways to help those who had lost their health care coverage. Under the leadership of James D. Curry, MD, President, a committee was formed and similar health care projects throughout the state were researched. A survey of the physician membership was taken which resulted in almost 100% participation in offering free medical care. Some of our physicians had already extended continuous care if aware of a financial problem.

With the cooperation of Mansfield General Hospital, United Way, Richland County Welfare Department, Richland County Health Department and many others too numerous to mention in this letter, PROJECT HEALTH CARE began to function. This program is being administered from the office of the Richland County Medical Society. However, during the formation and in the early days following, the Society was without a secretary and the program was manned entirely by volunteer members of the Medical Auxiliary. We should add here that Richland County dentists offer their services.

Our eligibility criteria is simple — unemployed and without health coverage. In a few cases, with special circumstances, we have obtained free medical attention for those with very limited employment but no health care coverage. We are aware of the stress-related problems of the unemployed and, like other such communities concerned with the indigent, we are seeking ways to be of better service to those who come to us in need.

Sincerely,
Frances V. Cash
Secretary,
Richland County Medical Society
Mansfield, Ohio

Editor's Note:

Our apologies to Richland County and any other medical society which we may have missed in our coverage of health care for the unemployed. ("Reducing the Pressure," **Ohio State Medical Journal,** *November, 1983). Because of time and space limitations, we restricted our coverage to only those societies which had notified us of the programs they had implemented in their communities. We're certain that equally fine programs exist elsewhere in the state, and we regret not being able to mention them all.*

(The OSMA Journal *welcomes letters from its readers. Please address all letters to: Executive Editor, 600 S. High St., Columbus, Ohio 43215. Letters may be edited to meet space requirements.)*

The New Ethics

There you are, at the patient's bed — being asked questions. Tough questions, thorny questions — questions no one would have had to ask of their doctors ten, twenty, thirty years ago.

"Shall my baby have the operation, doctor? I know it will keep her alive, but what kind of life will she have?"

"How can you ask me for his heart? If it's still so good, why isn't he still alive?"

Medicine has come a long way. Advances in drugs, technology and medical techniques are making what used to be considered "modern day miracles" seem almost commonplace today. But with new knowledge comes new responsibilities. New decisions now have to be made which go beyond the scope of medicine as a science.

Suddenly, you, the doctor, are being thrust onto a whole new plane of moral and ethical dilemmas. Now, there is so much more to be considered than "how can I keep this person alive." It used to be, you couldn't. Medicine just didn't have the means to allow you to do so. But now that you *can*, people are asking you if you *should* — and what kind of question is *that* for a physician?

Unfortunately, it's one of those questions that is being asked more and more frequently these days, and not just by the public. Government, too, is prompting a whole new set of ethical questions, with cost figures uppermost on its mind, and an unusually strong interest in protecting patient rights never far from its thoughts.

This issue of the *Journal* does not attempt to address all the problems, both moral and ethical, which have arisen in recent years. Nor does it attempt to find answers or solutions. Instead, we explore some of the more prominent issues which have come to the forefront in recent months, and present them for you to consider. We hope they prove to be as thought-provoking for you as they proved to be for us.

Suddenly, you, the doctor, are being thrust onto a whole new plane of moral and ethical decisions. Now, there is so much more to be considered.

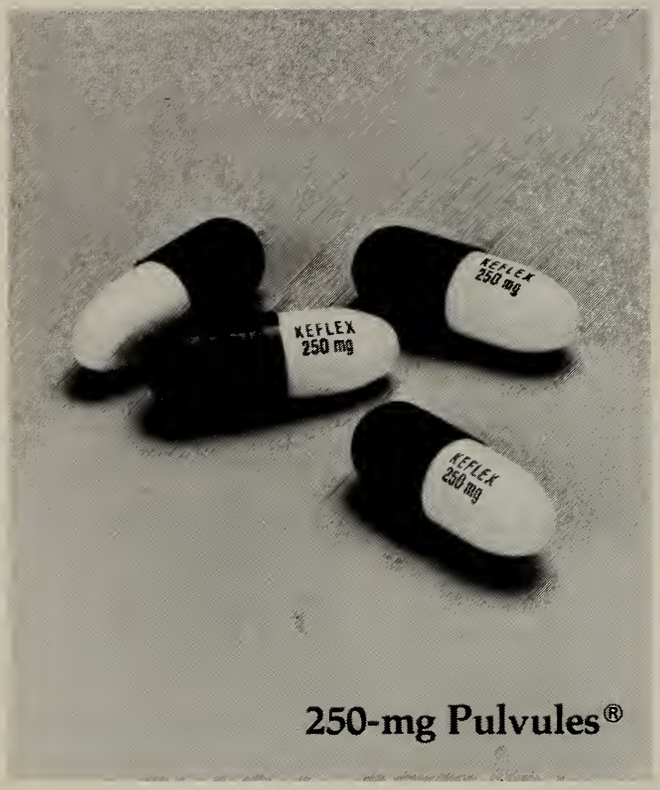
We also take a look at legislation — some of the medical bills which are currently in the legislative review process. Our Legislation Committee and Legislative staff have been working diligently this year to present medicine's view of these bills. Once you read them, you'll understand why.

And don't miss the article on Wright State University's Aerospace Medicine program. It looks like all the "right stuff" needed for the nation's medical space program is located right here in Ohio.

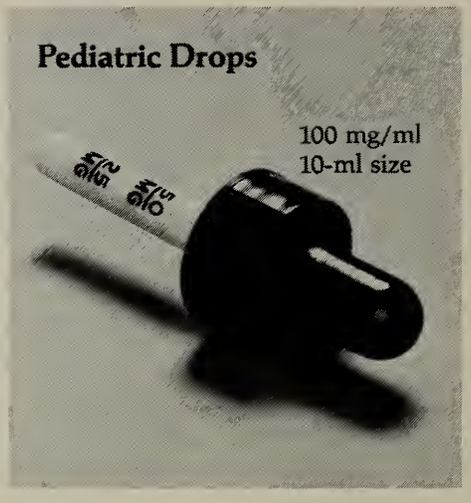
We hope this issue will present some views you haven't considered before — as well as those you have. We hope this issue will make you think, and, in some cases, maybe act. After all, you're the doctor . . . you're the one to whom the public, the government, and especially your patients, are turning for answers. It's something to think about.

— *Karen S. Edwards*

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The Status Quo Is No Longer an Option

By Jack Methany, MD

Cutting the cost of medical care is an idea thats time has come. This will involve the way we practice medicine as well as the way we are paid. I only hope that organized medicine is not too late to be included in the process of reassessing the health care delivery system.

To be heard, we must develop a credible, logical, defensible position. To do that, we must arm ourselves with facts and get our personal philosophies in tune with our actions. We are not faced with a medical problem. It is a social problem. Indeed it is a class struggle.

Physicians have long been part of a privileged class. We are not part of a ruling class. We have earned our position in the past and we must continue to do so. We have no God-given nor even constitutional right to impose the present monolithic, semi-monopolistic medical care delivery system on the general public. Not only do we not have the right to insist on "more of the same," we probably do not have the power to resist change. In a democracy, the ruling class is the voting class. There are more non-physician voters than physician voters. We cannot expect people to vote against their own perceived interests. We must therefore address the perceptions of the man on the street.

We have lost public sympathy because we have so often appeared to be speaking out of both sides of our mouths. We have cried for free choice and competition, but when it comes, we seek to limit the numbers of new doctors and curtail the role of perfectly adequately trained ancillary professionals. We seek refuge from PPOs, HMOs, IPAs, DRGs, PRSOs and so on. We have proclaimed the greatness of America's free system, then rushed to slam the door on foreign graduates, regardless of their clinical or social skills (some do speak English — and three other languages — quite well). We profess concern for all the citizens of our state, but many well respected physicians refuse to accept Welfare cards, thus shifting the burden to others. We bemoan the high costs of office overhead as we write out a check to our receptionist for $4.00/hr. How much sympathy can we expect from our own employees if they feel they and the patients are being exploited?

I only hope that organized medicine is not too late to be included in the process of reassessing the health care delivery system.

We loudly proclaim everybody's right to modern and equal medical care from the doctor of his or her own choosing, but refuse to support a tax base that would make that possible and refuse to see Medicaid patients because the government will not pay enough. Heaven forbid that the government tries to save money by asking us to look at each other's charts!

To hail one's right to abortion while remaining silent on the "squeal rule" might lead the public to conclude that there is more money in deliveries and abortions than in family planning.

We often speak of the individual's dignity and then show by our words and deeds that we really regard many of our patients as mentally retarded derelicts who chose to abuse themselves as well as the entire medical care delivery system.

Aside from the question of public perceptions of us, what do we think of ourselves? What is our personal attitude toward social justice? I would submit that most doctors have not yet decided whether they are divine instruments of healing or devout disciples of Adam Smith's laissez-faire capitalism. Doctors as individuals are soon going to be forced to take stands on social issues that face society in general. Medicine is being singled out at present for cost containment but this is just the tip of the iceberg. There is an ever increasing demand that limited resources be more equitably divided.

Yet even if redistribution of wealth was desirable or possible, the American people cannot afford the

continued on next page

present health care model which puts spending at a staggering $322,000,000,000.00 a year! And even at this rate, it is a great mistake to suggest that equal care is provided for all in need. But even if access to care were to be improved, under the present system, the costs would only go up. And significant cost increases simply will not be tolerated by those paying the bill.

Cost control is not a medical issue. It is a political, philosophical, and economic issue. Free choice in health care is a myth. The wrong individuals are rewarded and penalized. The person who lives a healthy lifestyle and buys full coverage insurance pays not only for his or her care but for that of those less thoughtful, through higher premiums and taxes.

To cut medical costs, we must ask some tough social questions. How many killer crops of tobacco must we subsidize? How many mangled bodies do we have to bolt together or bury before we get the drunks and speeders off the road? Who will say that it is wrong for a laborer to toil in the mid-day sun, only to be taxed to pay for the hopes of an unrealistic mother demanding "free and appropriate" education or surgery for her hopelessly retarded and deformed child? Who can refuse that mother, knowing that the same taxing institutions are spending vast sums of money entertaining government contractors?

Who has the guts to say that terminally ill patients should be encouraged to die comfortably in their own homes with plenty of demerol, surrounded by loved ones, rather than be condemned to the slow torture of repeated disappointments from chemotherapy, I.V.s, NG tubes and strangers in a strange place?

And how cost effective can it be to have government policies that not only result in people becoming unemployed but also plunge them into despair and anger because regulations demand that one gives up virtually every shred of self-esteem before the "dole" will start? I have seen men forced to leave their families so the wife and child could claim desertion in order to get food stamps for mere survival.

As far as the chronically unemployed are concerned, we constantly violate their dignity by giving them just enough to perpetuate their plight. But who is willing to violate their civil rights by sending them to forced training or work centers or demanding abortion or adoption of the children they are unable to support or rear?

The fact is that there is no paradise on earth. We shall always have to make compromises. What we must do, therefore, is seek compromises . . .

I have painted a picture of a society that has no vision, no well developed morals and no uniform goals. It is a picture of constant struggle between the "haves" and the "have nots," between the imaginative and the mundane, between the gifted and the robbed. It is a society that I would not have designed, yet it seems to have out-performed all other schemes concocted by the human race. Perhaps the great strength of our system is that nobody ever accumulates enough power to do irreparable damage. This same quality leaves us to suffer at the hands of inertia, thus crises tend to be solved rather than prevented.

The fact is that there is no paradise on earth. We shall always have to make compromises. Even such admirable goals as freedom and equality are mutually exclusive when carried to their extremes. There is no average citizen. Whenever one class of individuals prospers, another class must suffer . . . at least in comparison to what could have been.

What we must therefore do is seek compromises that bring reasonable gains to many, while protecting the bottom of the heap from unbearable burdens. This requires collection of solid data, guidelines for making ethical and moral judgments and power to institute the required reforms. In this country, that power requires the consent of the governed. Once a program has been developed it must be sold to the public.

I fear that when talking about cost control, the medical profession stands at square one. There is no compilation of a solid data base; therefore, even the most earnest and honest interpretations are virtually valueless. Collection of such data is not an impossible task, but neither is it a part-time job. The people best able to direct collection of data and to perform the analysis are in secure jobs making $100,000 a year. Can anyone reasonably expect such a person to give up job security and income to take on the headaches of prying information from hospital administrators, insurance companies, civil libertarians and large employers? To truly get an accurate picture of today's medical delivery system, multi-specialty teams of physicians would have to follow thousands of cases concurrently during hospitalization, examining every facet of a patient's care from the quality of bed linens to the medical expertise and practices of the attending physicians. This would obviously entail a great deal of money and some legislative action to open doors and protect individuals. Even in the best of circumstances, as in any scientifically planned research, the outcome is never a foregone conclusion, and the results may not be what we hoped for. In any event, I would rather deal with truth than postulate.

The task would be horrendous but the payoff could be great. In the computer age, once standards of care are developed, they can be universally

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Colleagues In The News

NORMAN S. CISAR, MD, Upper Sandusky, has been recently named diplomate of the American Board of Family Practice (ABFP).

LEROY G. DALHEIM, MD, Medina, was honored recently for 25 years of service as health commissioner of the Medina County Health Department.

WILFRED B. DODGSON, MD, Youngstown, was appointed Chief of Pediatrics at Youngstown Hospital Association. Currently, Dr. Dodgson serves as director of Clinical Pediatrics and Neonatology at Youngstown Hospital Association.

JOSEPH FOLEY, MD, Cleveland, will be presented with the Ursula Laurus Medal from Ursuline College in Cleveland. Dr. Foley is professor of Neurology at Case Western Reserve University.



William H. Gates, MD . . . new Cincinnati Academy President

WILLIAM H. GATES, MD, Cincinnati, was appointed president of the Academy of Medicine of Cincinnati.

WILLIAM H. HAVENER, MD, Columbus, is one of the founding pioneers of the Ohio Affiliate of the National Society to Prevent Blindness and was recently honored by the Society at its semi-annual meeting and fall conference as one of the two first-time recipients of its Founders' Award. Havener, professor and chairman, department of ophthalmology, at the Ohio State University has been active in the Ohio Society's vision efforts since its founding in 1957.

THOMAS R. HAVRILLA, MD, Steubenville, is the new director of radiology at the Ohio Valley Hospital.

LAWRENCE LEVY, MD, Cleveland, has been named Director of the Post-Mastectomy Rehabilitation Program at the Mt. Sinai Medical Center. The purpose of the program is to promote excellent emotional and physical patient care.

LEROY W. MATTHEWS, MD, Cleveland, was recently honored at Mt. Sinai Medical Center for his worthy contributions toward research in cystic fibrosis.

WILLIAM M. MICHENER, MD, Cleveland, is a new appointee to the graduate medical education advisory committee of the American Medical Association.

LAWRENCE A. PABST, MD, Galion, will serve as chief of medical staff from 1983 through 1984 at Galion Community Hospital.

ALEXANDER POLLACK, MD, Columbus, has been selected by the Ohio State University's department of medicine to receive the second annual Clinical Faculty Teaching Awards for outstanding contributions to medical education.

RICHARD D. RUPPERT, MD, recently was awarded the Ohio University College of Osteopathic Medicine's Phillips Medal for enhancing the quality of health care.

Cleveland physician receives Albert Lasker Medical Research Award



F. Mason Sone, Jr., MD

F. MASON SONE, JR., MD, Cleveland, was recently awarded the prestigious Albert Lasker Medical Research Award for developing a technique which has made life-saving coronary bypass surgery possible. Dr. Sones, a cardiologist at the Cleveland Clinic, developed a diagnostic technique called coronary angiogram, in which high-speed X-ray moving pictures measure the heart's activities, pinpointing the blockage of an artery.

KEITH A. WATSON, MD, Greene County, has been appointed medical director of Greene County-combined General Health District.

ROBERT S. YOUNG, MD, Johnstown, was named treasurer of the American Academy of Family Physicians (AAFP) at its recent Annual Meeting in Kansas City, Missouri.

ROBERT M. ZOLLINGER, MD, Columbus, was recently honored by the Department of Surgery at the Ohio State University in recognition of his 80th birthday. A day long seminar was held during which various papers were presented. Highlighting the celebration was an evening banquet with keynote speaker, Woody Hayes, former Ohio State University head football coach.



a compilation of the latest developments, reports and products of interest to physicians.

edited by Susan Porter

House calls back in business



Growing competition in the health care industry and a gap in the health care delivery system has resulted in the formation of some new business enterprises now springing up across the country. The old-fashioned physician house call is now being offered for certain patients in certain locales, according to a recent report in *Medical World News*.

The programs, known by names such as "S.O.S. Doctor" in Los Angeles and "House Call MD" in Santa Monica, are designed chiefly for those who cannot easily get to a physician's office: the elderly who lack transportation, those too sick to make the trip, housebound mothers and their small children, etc. For a fee ranging from $55 to $75 during daytime hours and around $100 at nights or on weekends (usually paid, in part, by insurance or Medicare), physicians will visit the home to make examinations, draw blood samples, take throat cultures and even deliver sample doses of antibiotics, according to the report.

While doctors making home visits may lack the equipment and technology available to them in the office setting, they are afforded the opportunity to examine the patient in his/her own environment, noting stress factors, living conditions and the health of other family members. Physicians also can devote more energy and attention to the patient without interruptions by other staff, patients or phone calls.

The services are being sponsored by physicians, physician groups and hospitals, and are seen as good public service tools or ways to get the sponsor's name before the public. Most operate 24-hours-a-day and thus supplement the services of physicians not available after hours.

Physicians hired by the service — many third-year residents at local hospitals or doctors just getting started in private practice — generally are paid a flat and comparatively modest fee. Still, many of the services are finding it difficult to stay in business due to the expense and time involved in transportation and the relatively small number of patients they can see each day.

However, a similar service which has been operating in Paris, France since 1966 makes some 1,000 house calls a day and does $6 million a year in billings.

Hope for head injuries

Persons who suffer head injuries — both mild and severe — may continue to experience marked improvement, not only during the first six months after the incident but even beyond the first year.

This was one of the major highlights of a study recently reported in the Archives of Neurology, centering on the neuropsychological functions of 45 adults who had suffered a variety of head injuries and their 18-month recovery periods that followed.



Previous reports had indicated that patients with head injuries experience substantial recovery during the first year, particularly the first six months, and then a subsequent leveling of improvement curves, say the researchers who conducted the study at Seattle's University of Washington. "Our findings, however, give little evidence that improvement in neuropsychological deficit areas slows appreciably after the first year."

The study also indicates that higher-level mind functions seem to be more vulnerable than lower-level functions, and that improvement following losses in functioning occurs in complex as well as in simple functions. In addition, it was determined that the degree of initial deficit is a significant determinant of the subsequent amount of recovery and of residual deficits.

Head injury is a major area of concern in medicine because it is the leading cause of brain damage in previously healthy young adults. Also, improved medical management has increased the number of survivors of accidents involving head injuries.

FDA issues new drug study, list



A new list of the nation's safe and effective non-prescription drugs has been issued by the Food and Drug Administration. Many over-the-counter products have been pulled from the shelves, while some prescription products have been given over-the-counter status.

The FDA recently concluded a comprehensive, 11-year review of drugs, scrutinizing 700 key ingredients used in non-prescription drugs. Only one-third of the ingredients reviewed were found to be both safe and effective for the uses for which they are intended.

Because of the study's recommendations, consumers can now buy a number of former prescription drugs over-the-counter. They include: hydrocortisone, two antifungals, seven antihistamines, diphenhydramine hydrochloride, diphenhydramine monocitrate and dyclonine hydrochloride.

Among the many over-the-counter products removed from the shelves are sweet spirits of nitre, camphorated oil, hexachlorophene, tribromsalan, zirconium, bromides, scopolamine and all daytime sedative products promoted to relieve "simple nervous tension."

Not all drugs removed from the shelves were deemed "unsafe"; rather, some simply were considered "ineffective" by the FDA's 17-member advisory panel for the uses for which they are intended. Also, some products contain both effective and ineffective ingredients.

The full impact of the report and subsequent regulations will be forthcoming.

Malnutrition is problem

Hospitalized patients who are undernourished can experience serious problems recovering from their illnesses, the director of nutrition services at Ross Laboratories in Columbus said recently during a nine-city teleconference. Susan Calvert Finn told some 2,000 physicians, nurses and other health professionals that proper nutrition can make the difference between life and death for the seriously ill; yet, it often is overlooked in the hospital care setting.



Because the body needs protein to heal itself following surgery, those who have not been receiving the proper nutrients, including the elderly and the sick, are poor surgery risks. Malnourished patients suffering from long-term diseases such as cancer or other forms of illness, may also have problems because malnutrition blocks the body's natural immune system and slows the healing process.

Modern nutritional therapy has been developed in the past decade which forces a lot of calories into the body and thus helps promote the healing process, Finn said. One of these is perenteral feeding — placing a catheter in the vena cava. This method costs approximately $200 a day. Because "malnutrition" is not on the list of Diagnosis Related Groups (DRGs), hospitals are not reimbursed for treating it.

Fortunately some Ohio hospitals — including four in the Columbus area — are addressing the problem and have established nutrition therapy teams to identify and treat malnourished patients, Finn said. However, a survey of hospitals conducted by Ross Labs found that only about 10% nationwide have set up such teams.

BOOK SHELF

Two books, edited by **MEIR GROSS, MD**, Cleveland, have just been released by Lexington Books/The Collamore Press. **Pseudoepilepsy: The Clinical Aspects of False Seizures,** discusses causes and suggested treatment of pseudoepilepsy. **Anorexia Nervosa: A Comprehensive Approach** takes a look at the seriousness of the illness and the complexity of treatment.

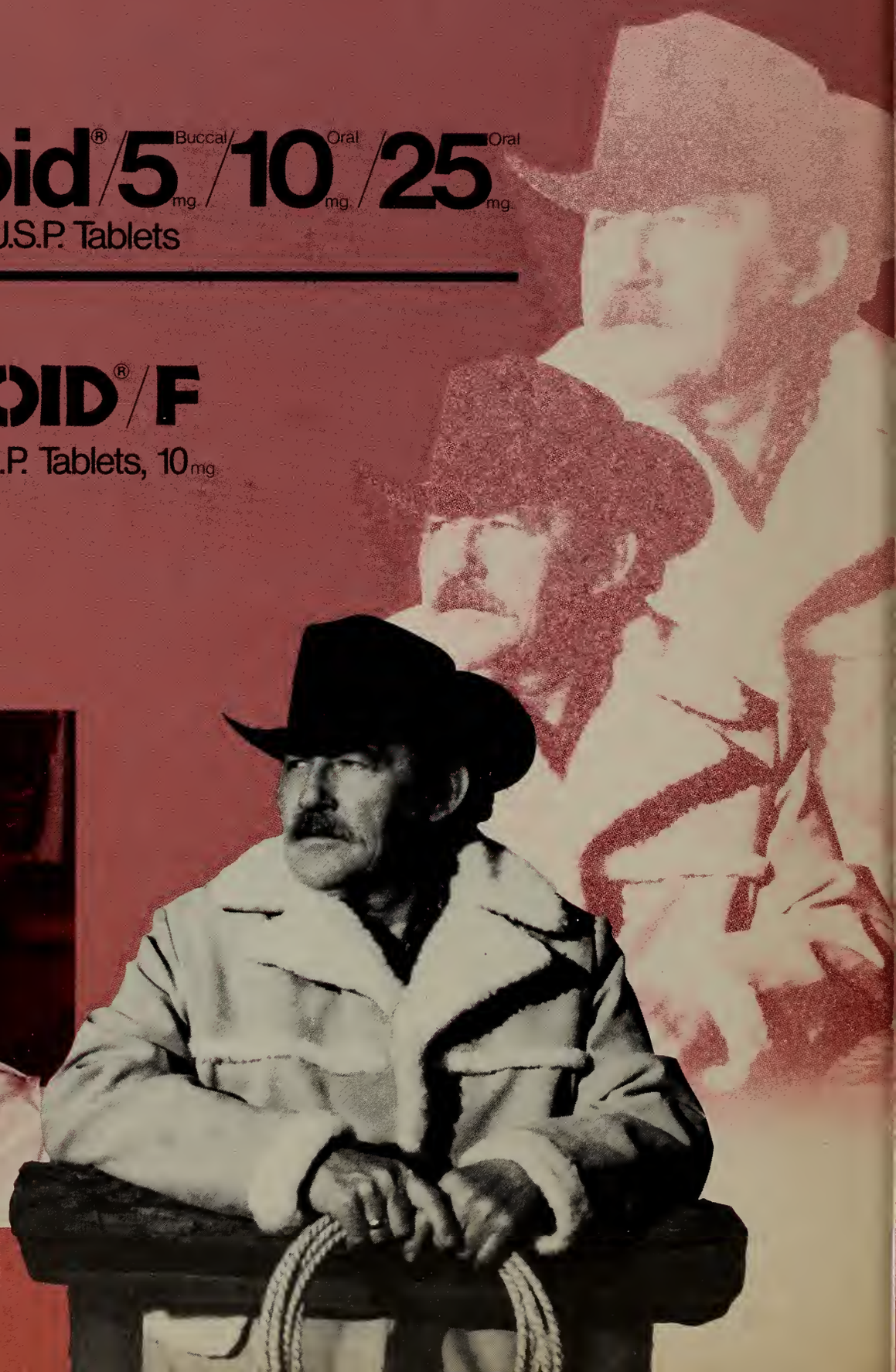
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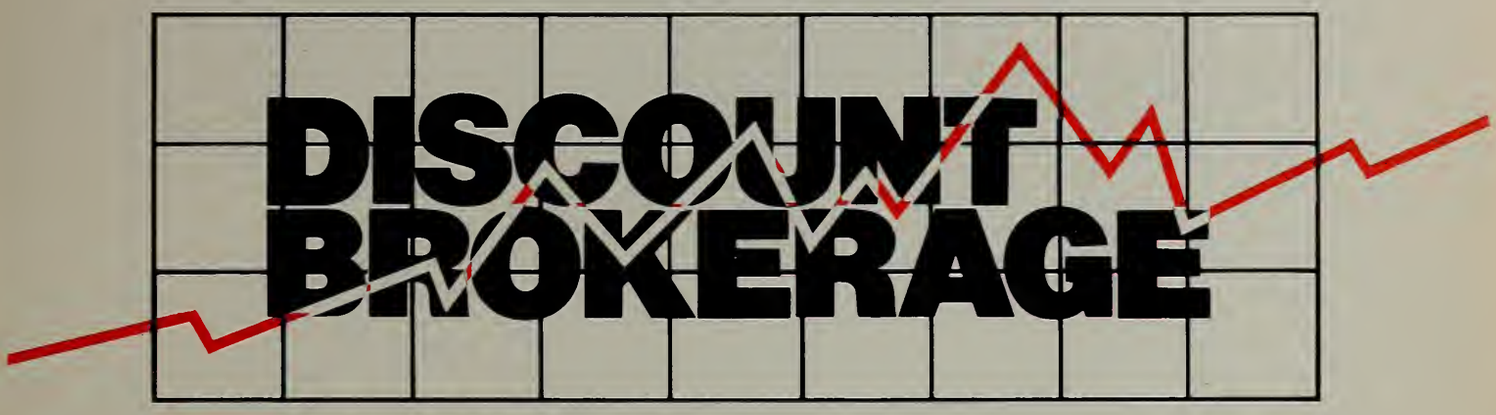
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A New Service for OSMA Members

By Carol Wright Mullinax

The OSMA recently announced the formation of its newest member service: the OSMA/Huntington Discount Brokerage Service. S. Baird Pfahl, Jr., MD, President of the Ohio State Medical Association, talks about this new plan and what it can mean for OSMA members.

JOURNAL: What prompted the OSMA to sponsor a Discount Brokerage Service?

DR. PFAHL: As a service organization, one of the ways the OSMA measures its success is in its ability to anticipate and respond to the needs of its members. I believe there are a large number of OSMA members who are either involved in the stock market or want to become involved. Many of these physicians neither need nor want the expertise or cost of a full-service brokerage firm. I don't think it is any secret that physicians have the reputation of being independent thinkers. By using this new service the physician can get first class service in the stock, bond and options market without having to pay for something he doesn't need, i.e., management of his portfolio or advice on when to buy and sell or what to buy and sell.

JOURNAL: Could you describe how the discount brokerage service works?

DR. PFAHL: Certainly. To take advantage of this new service, all a member has to do is establish a discount brokerage account at the Huntington National Bank either by completing the application form included in the November *OSMAgram* or by calling the Huntington directly. (The numbers are printed below.) Then, when the physician wants to buy or sell, all he or she has to do is call the Huntington and notify it of his or her decision. For example, if the physician wishes to buy security, he or she informs the bank and the bank sends a written confirmation of the transaction the next day. The member has until the settlement date to get the money into his or her account. The member may deposit money into the brokerage account either by mail or by depositing it in any Huntington Branch Bank.

JOURNAL: What about OSMA members who do not live near any Huntington Branch Bank?

DR. PFAHL: That is what is so

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continued

convenient about this plan. Participants may complete all of their transactions by phone and mail, so they do not need to live near a Huntington Bank Branch office. However, if they live near a Branch Bank and prefer to use it, they can. Also, I think it is important to stress that the physician does not need to have any other accounts with the Huntington Bank. So members who have their business and personal accounts at other banking institutions do not need to switch.

JOURNAL: How much money does an OSMA member stand to save by taking advantage of this new service?

DR. PFAHL: Our research shows that this new service can save members as much as 70% off of full-cost brokerage commissions, depending on the type of transaction. For example, if a member wanted to purchase 300 shares of a stock which sells for $20 a share, he or she would pay approximately $138 in brokerage fees to a full-cost broker. This figure is based on the average commission charge of five leading firms as of August, 1983. That same transaction with the OSMA Huntington Discount Brokerage Service would cost only $55 — a savings of $83. For larger transactions, the savings are even greater. If a member wanted to purchase 1,000 shares of a stock selling at $40 a share, he or she would pay approximately $529 in full cost brokerage fees, again based on the average. That same transaction would cost only $150 with the OSMA/Huntington service — a savings of $379.

Our research shows that this new service can save members as much as 70 percent off of full-cost brokerage commissions . . .

JOURNAL: Besides the substantial savings, are there any other advantages of using this new Discount Brokerage Service?

DR. PFAHL: Yes, there are many other benefits. First, there is the peace of mind that comes with knowing that you are dealing with a first-class, reputable firm. The OSMA investigated this service thoroughly before recommending it to the members. Secondly, I think the convenience of the plan is a big advantage. Members have access to any stock listed on any exchange, as well as the bond and options market, with one phone call. Finally, I really think the physician should not overlook the money he or she stands to save without sacrificing anything. It has been my experience that there are a lot of physicians out there making their own stock market decisions anyway. Why should they pay full price for a service they don't need?

I urge all members to contact the Huntington for a complete Independent Investor Kit and to take advantage of this new service.

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Carol Wright Mullinax is Associate Director, Department of Communications, and a Contributing Editor to the Journal.

Second Opinion

continued

applied and monitored, thus removing arbitrary decisions from our prerogative and perhaps making us better doctors and citizens.

On the other hand, if we continue our present trial and error approach to medicine and life, let us not be ashamed to fight for our turf. After all, what other facets of our lives are subjected to the scientific model? Why should we permit medicine to be singled out as the greatest threat to the American pocketbook? If we cannot be persuasive by reason, we must at least be persuasive by unity. Cost control is coming. We must either gather data to help us control and explain the process, or we must come to accept the role of rationing agents for a limited resource. No one else will accept that responsibility and we will not be able to avoid it. **OSMA**

"Second Opinion" is a column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy. The JOURNAL encourages individual members to submit articles for this column. Preference will be given to short, concise articles which discuss the current issues of the day.

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Who Is Responsible for Baby Doe?

By Leonard P. Rome, MD

Editor's Note:
The "Baby Doe" Regulations refer to the regulations regarding "Nondiscrimination on the Basis of Handicap Related to Health Care for Handicapped Infants," as published in the **Federal Register** *of July 7, 1983 (48 FR 30846). It was to go into effect on September 6, 1983.*

The "Baby Doe" incident refers to a case in Bloomington, Indiana. It is alleged that in April, 1982, the parents of a child born with Down's Syndrome and surgically correctable esophageal atresia refused to consent to surgery for the child. The child's anomaly precluded provision for enteral nutrition. No parenteral nutrition was provided. The hospital petitioned the state court; a guardian was appointed, and an appeal was made. Before final judicial intervention at the United States Supreme Court level could be sought, the infant died on day six. On April 30, 1982, President Reagan sent a memorandum to the Attorney General, citing the "Baby Doe" case and noting that federal law prohibits discrimination against the handicapped. In response, the Secretary of the Department of Health and Human Services issued a May 18, 1982 "notice" to health care providers "to remind affected parties of Section 504 of the Rehabilitation Act of 1973, which made it unlawful for hospitals receiving federal financial assistance to withhold from handicapped infants nutritional sustenance or medical or surgical treatment if required to correct a life-threatening condition."

The Baby Doe Rule permits the government to participate in the patient-physician relationship . . .

On March 7, 1983, Health and Human Services (HHS) issued an "interim final rule" concerning nondiscrimination on the basis of handicap. It was issued with 15 days' notice and required the posting of a notice in each delivery ward, maternity ward, pediatric ward, nursery and intensive care nursery, stating that *"Discriminatory Failure to Feed and Care for Handicapped Infants . . . is Prohibited by Federal Law."* Also, it set up a Handicapped Infant Hotline, i.e. another squeal law. The rule invites anonymous reporting of suspected mistreatment of seriously ill infants. The Baby Doe Rule permits the government to participate in the patient-physician relationship and further, the rule permits the privacy of this patient-doctor relationship to be invaded by anyone at any time — the head nurse, the janitor, etc. The United States District Court in April, 1983 struck down the rule (*American Academy of Pediatrics, et al, v. Heckler* [D.D.C. April 14, 1983]) on two grounds. It lacked a rational, factual basis, and it didn't allow advance public notice of the rule. The court held the rule to be arbitrary and capricious.

The saga goes on. On July 5, 1983, the second proposed rule was issued. This second proposed rule still has as its focus a 24-hour "hotline" and the posting of signs in hospitals. This time the signs are somewhat reduced in size, and they are required to be placed in the nurses' stations of the affected wards.

Everyone must agree that there is no more devastating event that can befall

continued on next page

The AMA's Stand

The American Medical Association believes the proposed rule is an inappropriate intrusion by the federal government into an area best left to families, physicians and community leaders. The federal government can contribute significantly to those having to make these difficult decisions if, instead, it encourages dissemination of reliable information concerning up-to-date methods for treating severely deformed newborns and if it helps to improve support systems and other community resources that could assist parents in caring for handicapped infants.

The American Medical Association objects to the proposed rule for the following reasons:

Justification for the Rule

- Federal agencies should focus their efforts upon determining the actual extent of severe impairment in newborns; explore the issues involved in their treatment; assess the availability of facilities and resources and the capacity of voluntary and state agencies to provide assistance; and evaluate such factors as impact of various options on the families of the severely handicapped newborn, confidentiality of the physician/patient relationship, and malpractice and disciplinary risks faced by health care providers.

Effect on Families and Institutions

- The posted notice could increase the fears of expectant parents and create distrust of physicians and hospital personnel.
- Some individuals might perceive that the notice is posted to remedy prior improper actions of the facility.
- The rule provides no protection to families and physicians or institutions against frivolous and unjustified complaints by persons who may not be in a position to determine whether appropriate care is being given.

Liabilities of 24-Hour Access by Government Investigators

- The proposed rule does not clarify what circumstances warrant immediate access.
- Investigators without medical training may not be able to interpret records or the medical situation properly.
- The privacy of patients' medical records may not be protected.
- Giving investigators 24-hour access to hospital facilities and records could result in delayed treatment for some patients whose charts and orders are removed from the treatment area.

Ethics Committees

- Ethics review bodies should be established voluntarily by local hospitals and their medical staffs to assist parents, physicians and other members of the treatment team in decision making. Use of ethical review boards to assist in enforcement of the proposed rule would create an adversarial atmosphere rather than provide an open forum for sharing information and views.

Congressional Intent

- Congress did not intend Section 504 to be used to mandate medical treatment decisions or to require physicians or hospital administrators to override parental decisions regarding medical and surgical treatment of their children. The intent of Congress in enacting Section 504 was to provide the handicapped with access to education, employment, facilities and programs on the same basis as nonhandicapped individuals.
- The threat of penalties (termination of all federal financial assistance) may encourage physicians and hospitals to end participation in federally funded programs, particularly those supporting specialized treatment facilities for the newborn. Neonatal care units might be shut down to avoid the risk of losing federal funds, e.g. Medicare, essential to maintaining patient services provided by the institution.

parents than the birth of an abnormal or seriously ill child. The American Academy of Pediatrics, which had to sue the Federal Government to prevent implementation of these "Baby Doe" regulations, agrees with the Department of Health and Human Services of the Federal Government that the decision to treat or not to treat seriously ill newborns should not be based on concomitant handicapping conditions such as Down's Syndrome or other congenital anomalies. However, as physicians, we strongly oppose the remedy proposed by the Department of Health and Human Services. A better remedy, we believe, is the establishment in each hospital of an internal review procedure whenever the decision to forego life-sustaining therapy is being considered. The birth of an infant with a major malformation, or who is critically ill for other reasons, sometimes presents parents and physicians with an agonizing dilemma. In some cases (i.e., extreme prematurity), death is imminent regardless of treatment. In others (i.e., anencephaly), the child may be so impaired that treatment will serve only to maintain biological functions. These two conditions shouldn't create too much controversy. Yet there are some patients with malformations consistent with long and enjoyable life (i.e., Down's Syndrome); some whose future is more difficult to predict with the possibility of a wide range of function and/or suffering; others who are awaiting an imminent and unavoidable death. There is disagreement about the proper course of action in these cases, and the legal requirements are not yet clear. Withholding or withdrawing life-sustaining treatment is justified only if such a course serves the interest of the patient.

The proposed recommendation of the Committee on Bioethics of the American Academy of Pediatrics for consultation with hospital ethics committees when decisions are contemplated to withhold or withdraw life-sustaining treatment is consistent with the recommendations of the

President's Commission for the Study of Ethical Problems in Medicine. It preserves the responsibility of the physician to act as primary physician. It allows each case to be judged in all its complexity and individuality. It is responsive to public demands for a more thorough decision-making process. The guidelines say judgment by the single physician without the help of other experts cannot be justified. Life is always maintained while the "review" is underway. Parents would be involved in each step of decision-making.

The local review process could involve medical, legal, ethical and social expertise in an advisory manner.

The local review process could involve medical, legal, ethical and social expertise in an advisory manner. This process would promote infants' interests and protect physicians from charges of hasty or negligent decisions.

Federal intervention caused by the government's first attempts at a regulation ("Interim Final Rule," Fed. Reg. 9630 [March 7, 1983]) worked to the disadvantage of handicapped infants. The lack of knowledge of federal investigating teams, disruptions that occurred in nurseries would be detrimental to the infant.

The "Baby Doe" ruling may not result in lessening of suffering as proposed. The birth and subsequent care of a defective newborn results in emotional trauma to parents and nursery personnel, as well as physical pain to the infant, depending upon the anomalies. Some infants have severe

continued on page 25

And the case goes on ...

On October 20, 1983, in Port Jefferson, New York, another set of parents had to make the same type of agonizing decisions that haunted the Bloomington, Indiana parents early last year.

The New York parents were confronted with this choice: refuse surgery, in which case their daughter would probably die within two years, or go ahead with surgery, in which case the baby could survive into her 20s but be bedridden and severely retarded. The parents decided against surgery, whereupon a "right-to-life" attorney quickly filed suit to reverse the parents' decision. Although the trial court did order the operation for "Baby Doe," the court's decision was stayed by an appeals court. The case then proceeded to the State Court of Appeals, New York's highest court. There, the five Justices unanimously agreed to overturn the trial court's decision, and allow the parent's original decision, regarding the care of their infant daughter, to stand.

This case, like all the Baby Doe cases, will not end here, however. More litigation, and perhaps even government intervention will follow.

With regard to the New York Baby Doe case, the Justice Department has already said it may sue the hospital for access to medical records on the case. And, late last year, the House of Representatives was asked to take action on HR 1904, a bill which would reauthorize the National Center of Abuse and Neglect. This bill would require the Secretary of Health and Human Services (HHS) to develop procedural guidelines for establishing local health care mechanisms for the "review of care" provided to infants with life-threatening congenital impairments. States would be required, as a condition for receiving child abuse prevention grants, to have procedures to ensure that nutrition, medically indicated treatment, general care, and appropriate social services be provided to infants at risk with life-threatening congenital impairments. Child protective service agencies, health care facilities, health and allied medical professionals, such other agencies or individuals as a State may deem appropriate, social service providers, and courts of competent jurisdiction would be required to follow those procedures.

Provisions in this legislation could authorize the type of regulations that HHS has proposed, including hotlines, signs and investigations. Failure to comply with such regulations would jeopardize a state's child abuse program funding.

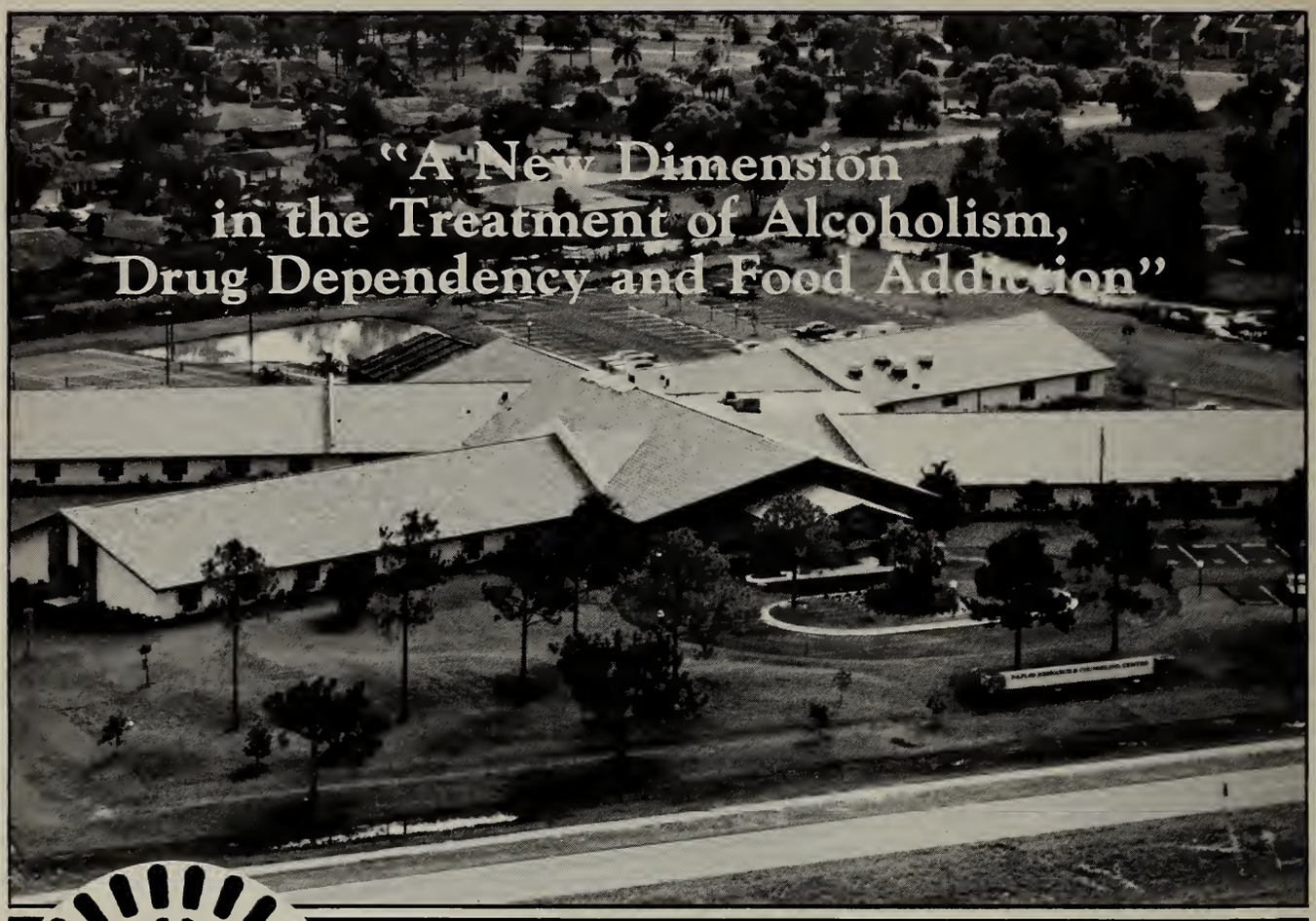
The law currently requires States to provide for reporting of suspected child abuse and neglect. The bill would expand this requirement to include a procedure for reporting to "appropriate authorities any known or suspected instance of the denial of nutrition, medically indicated treatment, general care or appropriate social services to infants at risk with life-threatening congenital impairments."

The American Medical Association and the health community, as a whole have come out in opposition to the proposed legislation — but they are not the only ones.

An editorial in the *Wall Street Journal* states:

"Our position (on Baby Doe) is that we do not presume to know what is the "moral" decision in each of these tragedies. Someone has to decide, which means that someone will make mistakes, as perhaps the parents of the Down's syndrome infant did in the original "Baby Doe" case, that started the current litigiousness. What we most certainly know is that, barring the most extreme circumstances, we do not want the decision made by some bureaucrat or some coven of lawyers. The inevitable agony will

continued on page 27



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or untreatable defects. To offer extraordinary support to these infants is to prolong their suffering by traumatizing them further with invasive techniques such as endotracheal intubation and placement of central venous or arterial lines. Such invasive procedures not only cause pain to the infant but hamper the development of normal parental-infant relationships.

In conclusion, all infants should receive humane and compassionate care regardless of the severity of the disease. Interjecting a federal presence into a highly sensitive area of parent-physician involvement with a severely handicapped infant, creating an atmosphere of suspicion and distrust, can only work to the disadvantage of parents and handicapped infants. This sensitivity precludes the "quick fix" solution which the "Baby Doe" rule would mandate. Physicians, parents, infant bioethics review committees, and society as a whole must deal realistically and compassionately with the complex issues to provide the proper treatment for the affected infants. **OSMA**

Leonard P. Rome, MD, Cleveland, is Clinical Professor of Pediatrics, Case Western Reserve University, and served as President, Ohio Academy of Pediatrics, 1982-83. He currently serves as alternate chairman, district five of the American Academy of Pediatrics.

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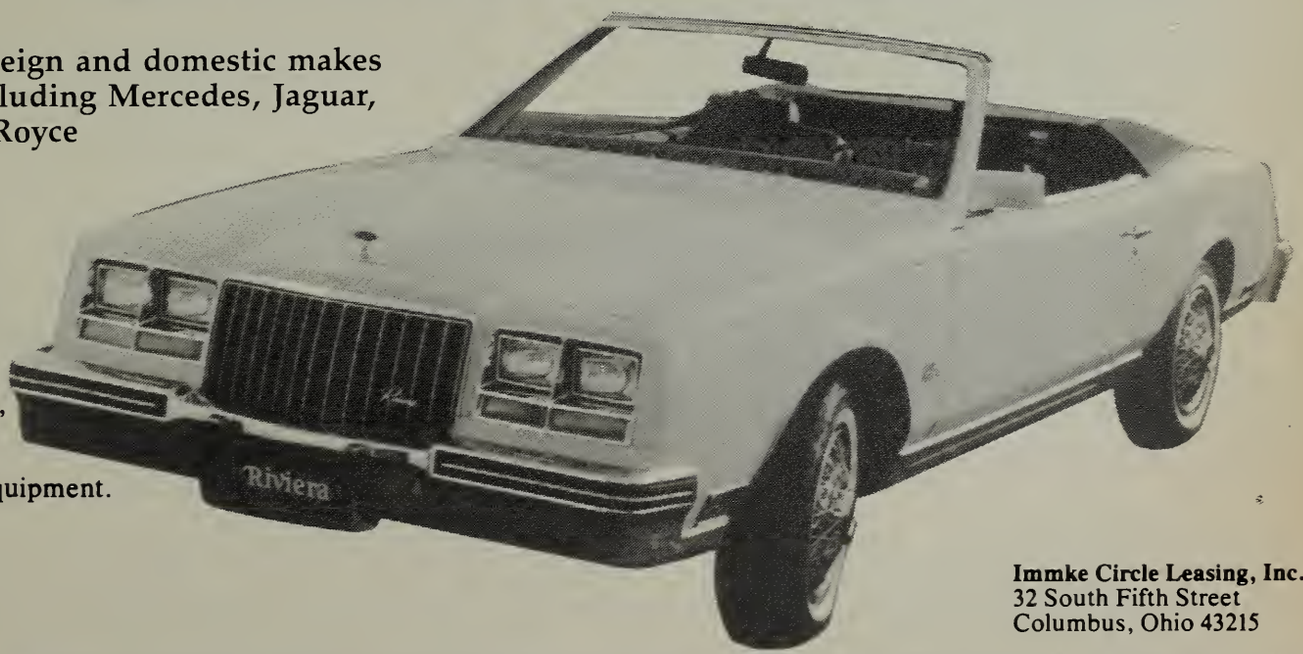
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*Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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And the case goes on . . .

continued

be much less if these decisions, and any mistakes, are left to the families involved: most often the families will decide on the basis of love, and in any event it is the family that must live with the resulting burden or guilt."

Closer to home, an editorial in the Columbus *Citizen Journal* says:

"We think the decision in this case, and others like it, is best left to parents and their physicians and religious advisers."

Just how far the Baby Doe cases will go is still undecided, at press time. (The Legislature has not taken any action on the bill so far, and is not likely to until later this month when the assembly reconvenes.) The fact remains, however, that the moral and ethical issues raised by the Baby Doe cases are going to be with us for a long time to come. — *Karen S. Edwards*

Quaalude production will cease this year

Physicians have until the end of this year to stop prescribing Quaaludes and switch their patients to another medication. Legal production of the widely counterfeited drug stopped last year, but medications in stock will continue to be distributed through January, 1984, giving doctors and their patients an opportunity to adjust.

The Lemmon Co. of Sellersville, Pa., decided to stop making the Quaalude brand of methaqualone last November, due to the "increasingly adverse legislative climate surrounding the product and the resulting negative publicity," according to recent newspaper reports.

Decline in the production of the sedative-hypnotic drug has been gradual; some 4 million Quaaludes were legally produced in 1973, compared to fewer than 300,000 in 1982.



Organ Transplants
PART ONE:
Ohio physicians getting involved

By Susan Porter

Thirty years ago, three physicians at a Boston hospital took one healthy kidney from a 24-year-old man and gave it to his identical twin brother who was suffering from terminal nephritis. It was not medicine's first attempt to transplant a human organ; for years, doctors had been working with "the idea of replacing diseased organs by sound ones," as is evidenced in an article that appeared in a 1908 issue of the *Journal of the American Medical Association.*

Yet, up until the early 1950s, efforts to transplant whole internal human organs had been marked with failure. The newly transplated organs repeatedly shriveled into masses of dead tissue and ceased to function, victimized by the patients' natural rejection mechanisms.

These Boston physicians, however, were optimistic, for they were operating on an important theory: that components which identify foreign matter in the body and activate the antibodies that act to remove it are genetically transferred. They were, of course, correct, and their 1954 operation resulted in what today is recognized as the first successful kidney transplant in the United States.

Since that time, tremendous advances have been made by doctors and researchers working to combat what remains the number one clinical problem in organ transplantation — rejection. Thanks to the development of better immunosuppressants, new transfusion and surgical techniques, and new methods of typing tissue and crossmatching the organs of donors and recipients, thousands of kidney patients have been spared difficult lives on dialysis.

Over the past five years alone, some 20,000 kidney transplants have been done in the United States; approximately 5,400 now take place, annually, with a notable number — around 400 each year — performed in



photo courtesy of the Health Services Audio Visual Television Center, the Ohio State University

Ohio. Ohio physicians have been involved in kidney transplantation since 1963 when the Cleveland Clinic initiated its program, according to Andrew C. Novick, MD, head of kidney transplantation there. Since that time, nearly 1,000 kidney transplants have been done at the Cleveland Clinic, alone, and today, kidney transplants are taking place on a regular basis in nearly all of Ohio's major cities, including Columbus, Cincinnati, Dayton, Toledo and Akron.

Cleveland holds the state record for the number of kidney transplants, but Columbus is quickly catching up — over 150 have been done at the Ohio State University Hospitals since Ronald M. Ferguson, MD, became director of Transplantation there in March of 1982. Dr. Ferguson and his associate director, Bruce G. Sommer, MD, also have been involved in the testing of the new drug, cyclosporine, making The University Hospital in Columbus one of only seven kidney transplant centers in the nation allowed to use the drug before its recent release by the FDA.

And while a short time ago — when many of Ohio's practicing physicians were still in medical school and first learning about transplantation — success rates were still so low as to classify this area as largely "experimental," today, "Transplantation is now a clinically proven method of treatment," Dr. Novick says. "Graft survival rates are outstanding and patient survival rates are even better. Transplants are no longer experimental — they have moved into the realm of clinically proven and effective means of treating patients."

No back-ups

To date, however, the overall acceptance of the whole organ transplant as a common means of treatment has been limited to kidneys, and for a number of reasons. One is financing. Since the early 1970s, the federal government has covered the cost of kidney transplants through Medicare, viewing its average $35,000 cost as an acceptable alternative to costly and indefinite dialysis. Other internal organ transplants, such as heart, liver, lung and pancreas, have not been covered by Medicare; nor have Blue Cross/Blue Shield or other third-party payers been anxious to pick up the extremely high cost of what they still term "experimental" procedures.

Also, more physicians have been willing to try kidney transplants because if the procedure fails, the patient can return to dialysis. Says Donald R. Steinmuller, MD, also involved in the renal transplant program at the Cleveland Clinic, "The problem with other transplant programs is there is no back-up if the transplant fails. With kidneys, you can always put the patient back on dialysis. But with the liver or the heart, if the transplant fails — if the new organ doesn't function properly — the patient dies."

And finally, because healthy individuals have two kidneys yet need only one to function, there is the option — as there was 30 years ago in Boston — of taking a kidney from a living blood relative with the same tissue type or antigen makeup. Also, because the kidney patient can function on dialysis, he or she can afford to wait for a good match from a cadaver donor, unlike the heart or liver patient who could easily die waiting.

Thus, until very recently, success rates in the transplantation of organs other than kidneys were so low that the cardiologist, the gastroenterologist or the pulmonologist rarely considered them an option. Even pioneer surgeons in the transplantation field began shying away from the area, as the rejection problem continued to bring failure to nearly all of their attempts.

A major breakthrough

All of this is changing, however, and it's possible that by the end of the decade, physicians in nearly every area may — at some time and in some way — be involved in or touched by the area of transplantation. The reason is cyclosporine, the new drug released recently by the FDA, which some are calling medicine's answer to the problem of rejection. Derived from a soil fungus, cyclosporine allows the body's immune system to continue to function; yet it suppresses its efforts to reject the organ.

While some Ohio physicians —

Out of all of the Americans who die each year, only about 20,000 are suitable for organ donation, so it's important that physicians recognize potential donors quickly so that the procurement process can be set into motion.

particularly those who have not had access to the drug until its recent release — tend to downplay the importance of cyclosporine in the area of kidney transplants, most admit its discovery is significant. "The potential now exists for a large amount of activity in other areas of transplantation — and a lot of other institutions and physicians will be getting involved," Dr. Steinmueller predicts.

The Cleveland Clinic plans to be the first in the state to perform heart transplants; as of the *Journal's* press time in mid-November, doctors there hoped to have a new program underway by the first of the year. Liver and pancreas transplants also will be taking place in Cleveland by the end of 1984, according to Dr. Novick.

J. Wesley Alexander, MD, director of the Transplantation Divison at the University of Cincinnati Medical Center, already has been involved in several pancreas transplants and says he probably will be doing liver transplants sometime during 1984. And physicians at OSU Hospitals in Columbus also are "talking about heart and liver transplants," according to Linda Jones, RN, organ procurement coordinator for the transplant program there, who adds, "Our surgeons are interested in developing more than just a kidney transplant program."

Yet with this increased interest in organ transplantation arise numerous questions and a lot of unsolved problems, many of which may prove as difficult to tackle as the rejection problem, itself. Most of these revolve around the issue of procurement, which, according to Dr. Novick, is "perhaps the biggest problem" in transplantation today.

For instance, there currently are some 120 patients waiting for kidney transplants at the Cleveland Clinic, alone, and their average wait is around nine months, Dr. Novick says. Because transplantation has rarely been considered an option with other organs, the potential number of Ohioans who may soon be on waiting lists for livers, kidneys, hearts and lungs is a virtual unknown, although in Cincinnati six are awaiting pancreas transplants.

Getting involved

Attempting to solve the problems of organ procurement are some 110 procurement agencies that currently exist in the United States. Most are hospital based, but 35 are independent, and the latter provide around half of the organs used in transplantation programs. Ohio currently has five procurement agencies which cover the state: Organ Recovery, Inc. in Cleveland, The Ohio Valley Organ Procurement Center in Cincinnati, and the Organ Procurement Agency of Northwestern Ohio are independent; Miami Valley Hospital in Dayton and OSU Hospital in Columbus also sponsor procurement agencies.

Special organ procurement coordinators are hired by each of these agencies to provide kidneys for the hospitals involved in transplantation in their areas, as well as to obtain organs for transplant programs taking place world-wide. According to Virginia Phillips, community hospital coordinator for the Organ Procurement Agency of Northwestern Ohio, a big part of her job is educating both the public and the professional about the need for organs and the process by which they are obtained.

"The biggest problem we have today is identifying potential cadaver donors," Phillips says — an aspect physicians are directly involved in, since they are the ones who must declare death. Out of all of the Americans who die each year, only about 20,000 are suitable for organ donation, so it's important that physicians recognize potential donors quickly so that the procurement process can be set into motion.

Rudy Morgan, senior transplant coordinator for Organ Recovery, Inc., says physicians are sometimes reluctant to get involved. Yet, "The physician in the community hospital plays a vital role in the recognition and management of donors," he says. "What those guys do in the emergency rooms of small community hospitals can make or break a transplant program."

Jones adds that accident victims —

continued on next page

It's possible that by the end of the decade, physicians in nearly every area may — at some time and in some way — be involved in or touched by the area of transplantation.



photo courtesy of the Health Services Audio Visual Television Center, the Ohio State University

those who die in motor accidents, drownings or from smoke inhalation — are most likely to suffer brain death and thus become candidates for organ donation. Among other potential donors are those who die from primary brain tumors, aneurysms and drug overdoses.

The potential donor's age is generally between six months and 65 years; he or she was in good health prior to the catastrophe, says Jones. Of critical importance is that — although the donor has suffered irreversible brain or cerebral injury — other parts of the body are still intact and functioning on a life support system. "There's no sense calling us if the heart is no longer beating," she says.

The attending physician should be certain, however, that brain death has occurred before the procurement agency is contacted; some hospitals have set criteria for determining brain death, while others leave it up to the physician. Once brain death has been declared, the physician must act quickly in contacting the procurement agency and in gaining the family's permission to retrieve the organs. Jones suggests that the procurement coordinator be contacted before the family is asked for permission, because, "There's nothing more detrimental than to have the family approached and then to find out that the patient does not meet the criteria."

Once it is determined the donor is suitable, someone — and often it is a physician — must bring up the option of organ donation to the family. "Legally, if the person is carrying a donor card or a marked driver's license, we don't have to ask the next of kin," says Morgan. "But ethically, we do. Still, I have never had a family turn me down in the presence of a donor card."

A loss and a failure

Still, many doctors — including a family physician who may be called upon by the next of kin to give advice in the situation — hesitate to get involved. "Psychologically, it's a difficult time both for the physician and the family," Dr. Alexander admits.

Says Phillips, "To declare someone dead is to some, an admission of failure. To tell the family the patient is dead is also like telling them he (the doctor) has failed. And, overall, physicians don't like to recognize that they have feelings, too."

Ron Dreffer, transplant coordinator at the University of Cincinnati Medical Center, agrees, pointing out that the conversation usually takes place under the worst of circumstances — the family has just experienced an irreversible tragedy and is in a state of shock and sorrow. Also, Dreffer points out, many physicians have difficulty dealing with death in any circumstances.

"Physicians also feel a loss — they have just lost a patient," Dreffer continues. "What they sometimes don't realize is that they are offering the next of kin an opportunity to make something good come out of a very tragic and senseless event."

According to Dr. Alexander, once physicians realize "how positively most families feel about donation — how it provides them with a good long-lasting feeling," they, too become enthusiastic about the option; they too are uplifted by the experience. **OSMA**

Susan Porter is Assistant Editor of the Ohio State Medical Journal.

Organ Transplants

PART TWO:
Questions and Controversy

By Susan Porter

Last year, the acting chief of staff at a Toledo hospital was confronted with a complex situation. A 13-year-old patient had been involved in an auto accident and declared dead, but was being maintained on a life-support system because the child's parents had agreed to organ donation. The kidneys were removed by a physician with credentials to practice in the hospital, but because the liver was to go outside the United States, a physician who did not have privileges within the country was flown in to "harvest" that organ.

Among the questions confronting the acting chief of staff who had responsibility for credentialing the visiting physician for privileges at his hospital, was, "Can a physician from outside the United States legally or ethically perform surgery in the United States, even though the patient has been previously pronounced 'clinically dead'?" Because the incident occurred after standard working hours, it was difficult for the hospital to obtain information on the surgeon's credentials or the transplant program in which he was involved. The acting chief of staff was also concerned about the fact the organ would be leaving the United States and wondered what national protocol was on this practice. Unfortunately, there were no immediate answers to any of his questions.

As can be seen from the above incident, the problem of physician involvement in the organ procurement process has not been strictly an emotional one. Until 1982 when the Ohio State Legislature passed legislation formally recognizing and defining brain death, some physicians worried that legal ramifications might result from declaring a patient dead whose organs still were functioning on a life-support system.

And today, physicians — along with political leaders, clergymen, insurance administrators and others — still ponder the social, financial, political and ethical problems that remain unsolved over who will have access to this difficult and expensive form of treatment.

Recently coming to the forefront of

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Please see next page for brief summary of prescribing information.

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR.)*
INDERAL® LA BRAND OF propranolol hydrochloride
(Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Last year, only half of the 10,000 Americans in need of kidney transplants received them, due to the shortage of organs. In Ohio, alone, some 460 patients currently await a new kidney.

the controversy is the potential for the retailing of organs. Ever since H. Barry Jacobs, MD, publicized his plans to start a business for the buying and selling of kidneys in Reston, Virginia, politicians and physicians alike have been screaming, "Foul!" As of mid-November, there still was no law prohibiting such an activity, although bills were before both the House and the Senate addressing this and other issues.

Among the first to speak to the question (and at least ten years prior to Dr. Jacob's scheme) was the Committee on Morals and Ethics of the Transplantation Society, which formally stated, "The sale of organs by donors living or dead is indefensible under any circumstances." More recently, the National Kidney Foundation issued a statement that it was "firmly opposed to the sale of donor organs for both medical and ethical reasons." Along with that statement, David A. Ogden, MD, president of the foundation, said at a national press conference last September, "The protection of a careful medical evaluation and protection of the donor's medical and psychological needs might be abrogated by a cash incentive for the donor, the hospital and the doctor." He also expressed concern that should a high price be placed on organs, only the very wealthy would be able to afford them.

The majority of physicians who have spoken out on the issue wholeheartedly agree, yet the matter is not as clear-cut as it seems. Last year, only half of the 10,000 Americans in need of kidney transplants received them, due to the shortage of organs. In Ohio, alone, some 460 patients currently await a new kidney. With the recent release of cyclosporine and the surge of interest that is expected to result, the need for kidneys, hearts, livers, pancreases, etc. is expected to soar over the next decade.

Yet, out of the estimated 20,000 Americans who suffer brain death each year, only about 2,500 become donors. While it may not be the ideal solution, at least one Cleveland physician feels that reimbursement for organs might act as an incentive to bring more donors into the program.

"In my opinion, it's not necessarily unethical to pay people for a kidney donation if they fully understand the risks involved and still want to go ahead with it," he says. "People take risks for money in other areas — certain jobs have high risk of injury or death, so we pay these people more money to do these jobs."

Along with the issue of allowing an individual to sell his/her kidney is a companion suggestion that the relatives of the deceased could be reimbursed for the organs of their loved one. Monies paid for cadaver organs might go into the donor's estate, the Cleveland doctor says, acting as an incentive for individuals to sign and carry donor cards and for relatives to honor them. "Mandatory reimbursement for that type of thing is not necessarily unreasonable," he says.

Still, this doctor feels strongly that "it is not appropriate to make money the reason why one person gets an organ and another does not." He suggests the federal government not only provide money to fund such operations (including the cost of the organs), but that it also be in charge of monitoring transplantation programs and providing the regulation necessary to insure that anyone in need of the treatment has access to it.

To date, this doctor says, most physicians have not been involved in this kind of activity because of the "great potential for legal problems and complications." But he adds, "It is certainly possible that in the future, there will be a much greater advantage to doing this."

At least one Cincinnati surgeon, however, has spoken out strongly against the concept of reimbursement for organs, calling it "One of the worst things that could happen to the transplant program." Similarly, organ procurement coordinators around the state express high concern over what they fear could bring an end to the volunteer program. "If you can get paid for them, who would want to give them away?" asks one.

Ron Dreffer, transplant coordinator at the University of Cincinnati Medical Center, comments, "No credible medical institution would ever become involved in a thing like that." And he continues, "We don't ever want to see a dollar sign attached to something that should be a gift. When you throw a life ring to someone who's drowning, you don't put a price tag on it."

Equally controversial is the current exportation of organ transplant programs in other countries, as well as the number of foreign patients coming into this country for transplants. Because the United States is far ahead of most countries in its transplantation programs, it's not unusual for non-residents to come here seeking care. According to a recent article in the *Wall Street Journal*, between 4% and 8% of the some 5,200 kidney transplants done here each year are on

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"We don't ever want to see a dollar sign attached to something that should be a gift. When you throw a life ring to someone who's drowning, you don't put a price tag on it."

foreign recipients.

In Cincinnati, says Dreffer, a number of Saudi Arabians have received new kidneys, although, "They get no preferential treatment. We are paid the same amount for them as we are for any other patient." Dreffer admits it's a touchy issue, but adds, "These are sick individuals who need help just like anybody else . . . Where do we draw the line? Do we refuse these people treatment because they're of a different nationality?"

In addition, a number of organs recovered in the United States are sent outside the country — such as the liver of the 13-year-old Toledo patient described at the beginning of this article. Kidneys recovered through the Organ Procurement Agency of Northwestern Ohio may go anywhere in the U.S., Canada, Europe, Japan or South America, according to Virginia Phillips, community hospital coordinator for that Toledo area agency.

Phillips points out, however, that Ohio procurement coordinators work together closely to make sure that those living in this and surrounding areas have first access to organs procurred locally. And according to Dreffer, most of those organs that do leave this country would otherwise be "wasted," either because there is no local match or because the organs are considered too old to meet U.S. standards.

As the *Journal* went to press, hearings on these and other issues surrounding organ transplantation were before the U.S. House of Representatives as a result of legislation proposed by Congressman Albert Gore, Jr. of Tennessee. The "Gore bill," however, not only addressed the issues of sale and distribution of organs; it also called for the establishment of a national transplant center and clearing house that would function under the Department of Health and Human Services. This presents another controversial aspect, as many believe the federal government should not directly involve itself in the administration of a medical program, particularly when an adequate framework already exists for organ procurement and distribution.

Beyond these complex issues lies an even larger question: how far should medicine go to advance this difficult and expensive form of treatment? Says a Cincinnati physician who feels transplantation will become much more commonplace over the next decade, "I don't think we will want to be transplanting kidneys into patients 85 and 90 years old."

And the questions continue to change. Over a decade ago, the Committee on Morals and Ethics of the Transplantation Society emphatically stated that "Transplantation of the brain should not be considered." Today, researchers are experimenting with the transplantation of brain cells, with promise this treatment eventually will alleviate some metabolic diseases. Even complete head transplants are not impossible goals for the next half century, according to recent newspaper reports of work done by a Cleveland neurosurgeon.

Still, the questions most Ohio physicians are likely to face are like those which recently confronted the acting chief of staff at a Toledo hospital who wasn't sure how to deal with a 13-year-old brain dead patient whose liver was to be removed by a foreign doctor for use in another country. And it's highly likely that until the many small details surrounding organ transplants are worked out, medicine and the society-at-large can't begin to answer the much larger questions that loom on the horizon.

WHO TO CALL

A 24-hour national hotline currently is sponsored by the North American Transplant Coordinators Organization, designed to give physicians and nurses current and specific information on organ procurement and placement. That number is: (800) 24D-ONOR or (800) 243-6667.

Health care professionals also may call directly the five organ procurement agencies in Ohio to seek assistance or information. Those agencies and their numbers are:

- The Organ Procurement Agency of Northwestern Ohio (Toledo area): (419) 893-4891.
- The Miami Valley Organ Procurement Agency (Dayton area): (513) 223-6192.
- The Ohio Valley Organ Procurement Center (Cincinnati area): (513) 872-5000.
- The Ohio State University Transplant Program (Columbus area): (614) 422-9794.
- Organ Recovery, Inc. (Akron/Cleveland area): (216) 231-4440. **OSMA**

Susan Porter is Assistant Editor of the Ohio State Medical Journal.

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MEDICAL LEGISLATION:

The Annual Checkup



By Eric Burkland

Editor's Note:

The following report is a partial list of medical legislation pending in the second year of the current biennium of the Ohio General Assembly. The Assembly will reconvene this month to consider these bills, as well as other health care issues.

A complete list of pending medical legislation has been sent to those physicians who participate in OSMA's "Key Physician" program, and also to those who are on the OSMA Auxiliary's Resource list.

Anyone wishing a complete list of the bills before the Assembly, or more information on any of the bills printed here may contact the Department of Legislation, The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215 (614-228-6971).

Allied Health Practitioners

HOUSE BILL 132 — LICENSURE OF MEDICAL RADIATION TECHNOLOGISTS (J. Thompson, D-Cleveland): H.B. 132 was drafted by the Ohio Department of Health to bring Ohio into compliance with the Federal Consumer-Patient Radiation Health and Safety Act of 1981. The bill creates an advisory Medical Radiation Technologist Board within the health department which would establish standards for licensure of diagnostic radiographers, nuclear medicine technologists, and radiation therapy technologists. This board would oversee implementation of a program for licensure of such technologists. The bill is in the House Health and Retirement Committee.

HOUSE BILL 181 — CHIROPRACTIC TEAM PHYSICIANS (Hinig, D-New Philadelphia): H.B. 181, introduced at the request of the Ohio Chiropractic Association, would include chiropractors within the definition of "medical practitioners" for purposes of limited immunity from liability while volunteering services to school athletic programs as "team physicians." The bill is in the House Civil and Commercial Law Committee.

HOUSE BILL 205 — SOCIAL WORK LICENSURE (Conley, D-Columbus): The bill would establish a licensure board with licensure and regulatory authority over counsellors and social workers. The bill would exempt physicians from the licensure requirements. The bill has passed the House and is in the Senate State Government, Health and Human Resources Committee.

HOUSE BILL 208 — PRACTICE OF PHARMACY (Conley, D-Columbus): H.B. 208 expands the definition of the practice of pharmacy to include among other things, "interpret and evaluate prescriptions, participate in drug selection and reviews of drug utilization and to advise consumers on

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the therapeutic values, contents, hazards and uses of drugs." The bill has one hearing in the House Health and Retirement Committee.

HOUSE BILL 358 — INSTITUTIONAL EMPLOYMENT OF PHYSICIAN'S ASSISTANTS (Mahnic, D-Cleveland): The bill would authorize the employment of physician's assistants by inpatient and outpatient health facilities and allow the employer to determine the services and functions a physician's assistant is competent to perform. The State Medical Board would be required to develop criteria that supervising physicians shall follow when delegating the authority to administer, order, dispense or prescribe drugs. The bill is in a sub-committee of the House Health and Retirement Committee.

HOUSE BILL 289 — ELECTROLYSIS (Orlett, D-Dayton): House Bill 289 would provide for regulation of non-therapeutic electrolysis by the State Board of Cosmetology. The legislation would create two classes of electrolysis: **Cosmetic Therapists** (therapeutic electrologists) and **Electrologist** (non-therapeutic). The Cosmetic Therapists would be regulated by the Medical Board, requiring 500 hours of instruction, and the electrologists would be regulated by the Cosmetology Board, requiring 125 hours of instruction. The bill has passed the House and is presently in the Senate awaiting a committee assignment.

SENATE BILL 187 — OPTOMETRIC DRUGS (Branstool, D-Utica): The bill would allow optometrists who meet specified education standards to administer specified topical ocular agents for the purpose of examination of the eye. The bill has passed the Senate and is in the House Health and Retirement Committee.

SENATE BILL 204 — CO-ADMITTING PRIVILEGES FOR CERTIFIED NURSE MIDWIVES (Schwarzwalder, D-Columbus): The bill would extend hospital co-admitting privileges to certified nurse-midwives and provide for direct reimbursement to nurse mid-wives for the services they perform. The bill has been passed out of the Senate State Government, Health and Human Resources Committee and currently is in the Senate Rules Committee.

SENATE BILL 205 — EMTs IN HEALTH FACILITIES (Valiquette, D-Toledo): The bill would prohibit EMTs from providing care in any health care facility. The bill would limit EMTs to providing emergency medical care at the scene of an accident, illness or injury and in the course of transporting victims to a health care facility. The bill is in the Senate State Government, Health and Human Resources Committee, but has not had a hearing.

Hospital Rate Commission

HOUSE BILL 471 — HEALTH DATA COMMISSION (Miller, D-Columbus): The bill would create an independent Health Data Commission within state government, which would require all hospital claims data from all third-party payers for compilation and public disclosure. The bill also would require standardized hospital billing. The bill has been assigned to the House Reference Committee and is awaiting assignment to a committee.

Reestablishment of HSAs

SENATE BILL 269 — CON MORATORIUM (Valiquette, D-Toledo): S.B. 269 would suspend for eight months action on any application for certificate of need determined to be complete on or after July 1, 1983 and would prohibit for eight months the development of any urgent care centers. The bill was introduced upon the request of the Director of the Department of Health in order to allow the Public Health Council time to develop new criteria for the certificate of need program. The bill is in the Senate State Government, Health and Human Resources Committee.

Health Care Facilities

HOUSE BILL 220 — ADULT DAY-CARE CENTERS (Hartley, D-Springfield): H.B. 220 provides for the regulation and licensing of adult day-care centers and the regulation and voluntary registration of adult day-care homes. Licensure and regulation would be a responsibility of the Director of Public Welfare. An "adult day-care center" is defined as a "facility that provides supervision during any part of a 24 hour day for six or more adults who need assistance in supervising their own activities." An "adult day-care home" would provide such services to two to five adults. The bill is in the House Human Resources Committee.

HOUSE BILL 433 — MEDICAL RECORDS (Pringle, D-Cleveland): The bill would require the preparation of finalized hospital records within 30 days after discharge; copies would have to be provided former patients upon a signed written request. The bill is in the House Health and Retirement Committee.

SENATE BILL 257 — HOSPICE LICENSURE (Fisher, D-Cleveland): The bill would establish standards for licensure of hospices in Ohio. The bill creates a Hospice Advisory Board within the Ohio Department of Health which would set standards for regulation of hospices and makes an appropriation of $68,000 for the current biennium to support start-up costs of the licensure program. The bill has not been assigned to a committee.

Health Insurance

HOUSE BILL 160 — HEALTH INSURANCE RISK SHARING PLAN (Nettle, D-Barberton): The bill would establish the Ohio Health Insurance Risk Sharing Plan to provide health insurance coverage for persons who have been denied, entirely or partially, coverage by private insurers for underwriting reasons. The bill is in the House Insurance Committee.

HOUSE BILL 215 HEALTH INSURANCE FOR UNEMPLOYED

(Gilmartin, D-Youngstown): The bill would authorize health insurers to form an association to provide group coverage to qualified unemployed persons and their spouses and dependents. House Bill 215 has passed the House and is currently in the Senate Elections, Financial Institutions and Insurance Committee.

HOUSE BILL 345 — HEALTH INSURANCE FOR UNEMPLOYED (Miller, D-Columbus): The bill would establish the Ohio Unemployment Health Insurance Protection Plan for recipients of unemployment compensation. The cost of the health insurance premiums would be withheld from the insured's unemployment compensation benefits. The legislation has been assigned to the House Committee for Insurance.

Miscellaneous State Regulations

HOUSE BILL 162 — BLOOD DONOR (J. Thompson, D-Cleveland): H.B. 162, introduced at the request of the Ohio Red Cross, would permit a 17-year-old to donate blood without parental consent. The bill was amended by the House to require parental notification. The bill has passed both Houses and has been signed by the Governor. It went into effect September 23, 1983.

HOUSE BILL 239 — CORONERS REMOVE EYES (Conley, D-Columbus): The bill would permit coroners to remove or authorize the removal of corneas during autopsies, if they have no knowledge of an objection by a decedent's next of kin. The legislation has passed the House and the Senate State Government, Health and Human Resources Committee and is presently in the Senate Rules Committee.

HOUSE BILL 302 — INFORMED CONSENT (Luebbers, D-Cincinnati): H.B. 302 established standards for giving informed consent to an abortion. The bill requires parental consent for the performance of an abortion upon an unmarried child, unless the juvenile court authorizes the child to act without consent. The bill is presently in the House Judiciary Committee.

HOUSE BILL 331 — DEATH WITH DIGNITY (Nettle, D-Barberton): H.B. 331 provides statutory recognition of "living wills" in Ohio. The bill protects physicians, other health care personnel, and health care facilities from civil or criminal liability when withholding or withdrawing life-prolonging measures in accordance with the directive or living will of a terminally ill patient. The bill is in hearings before the House Health and Retirement Committee.

SENATE BILL 263 — MEDICAL SCHOOL GRANTS (Speck, R-New Concord): The bill would establish a medical school grant program within the Ohio Student Loan Commission. The purpose of the grants is to recruit physicians into medically underserved areas of Ohio by a loan forgiveness mechanism. The bill has not been assigned to a committee.

Radiation

HOUSE BILL 29 — LICENSURE OF RADIATION SOURCES (J. Thompson, D-Cleveland): H.B. 29 revises current Ohio law regarding the Department of Health's program for registration and inspection of radiation-generating equipment. The bill was drafted by the Department of Health under the Rhodes administration, and would establish a registration and inspection fee for the program. The stated intent of the bill is to identify malfunctioning or poorly calibrated radiation-generating medical equipment. The bill is in the House Health and Retirement Committee.

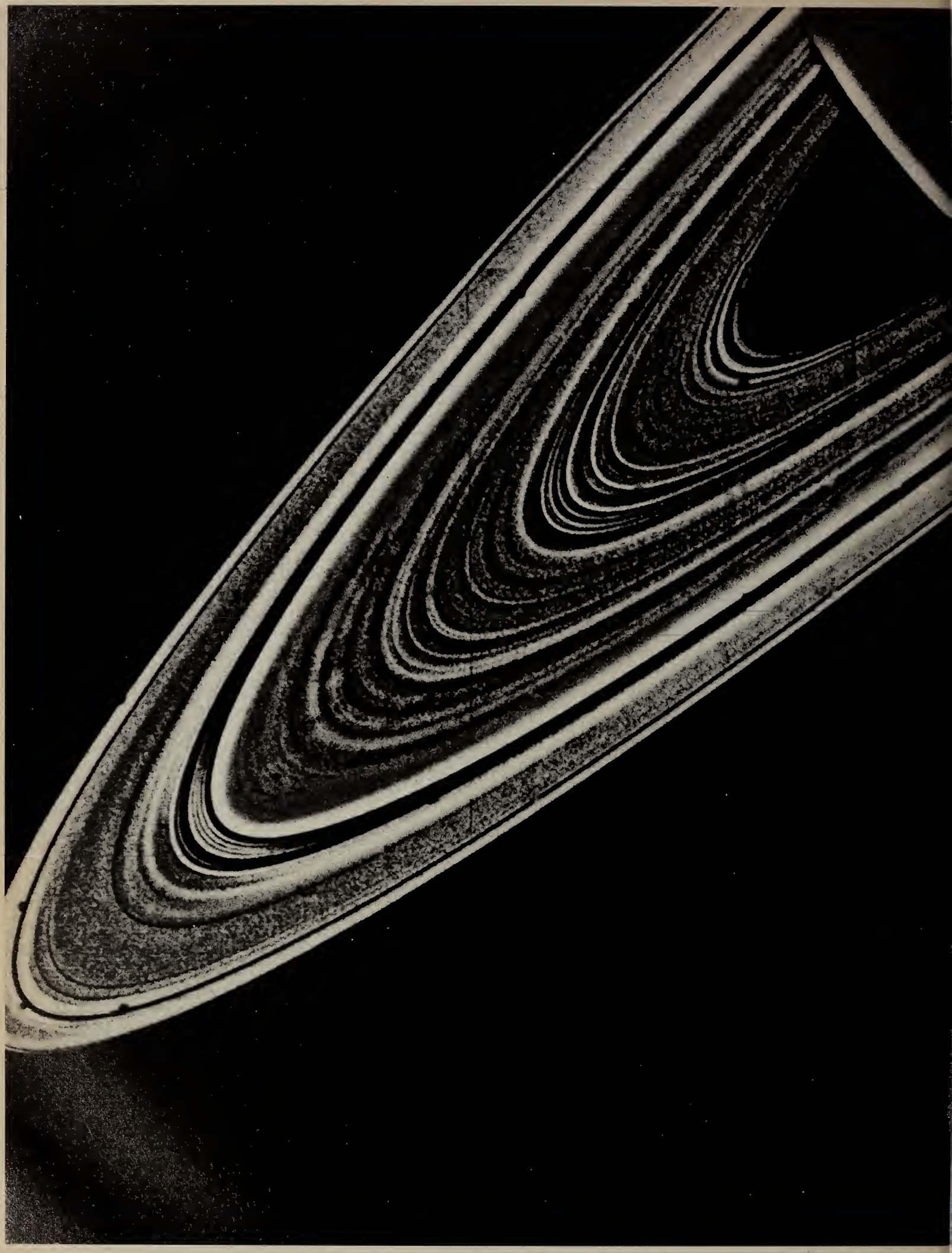
HOUSE BILL 344 — MIDWEST INTERSTATE COMPACT ON LOW-LEVEL RADIOACTIVE WASTE (J. Thompson, D-Cleveland): The bill would adopt the Midwest Interstate Low-Level Radioactive Waste Compact and create an Ohio Low-Level Radioactive Waste Advisory Committee. The bill was introduced in response to the Low-Level Radioactive Waste Policy Act enacted by Congress in 1980 which transferred to the states the responsibility for the management and disposal of commercial low-level radioactive waste either on a state-by-state basis or by region. The bill has passed the House and is awaiting a committee assignment in the Senate.

Medical Board

HOUSE BILL 549 — MEDICAL BOARD (Davidson, R-Columbus): The bill provides for the automatic suspension of a person's license to practice medicine if that person pleads not guilty by reason of insanity to any felony or misdemeanor. The Medical Board would be required to hold a hearing within thirty (30) days to determine whether the suspension should continue. If the person is found not guilty by reason of insanity, the Board would be empowered to continue the suspension if, in the opinion of not less than six (6) members, the person's actions were of such severity or nature as to destroy "public trust" in the person. The bill also adds conviction of a misdemeanor involving moral turpitude to the list of grounds for suspension or revocation of a license. The bill has not been referred to a committee yet.

HOUSE BILL 559 — MEDICAL BOARD (J. Thompson, D-Cleveland): The bill provides for the automatic suspension of a license to practice medicine if the holder pleads not guilty by reason of insanity to a misdemeanor or felony. The suspension would remain in effect until the Medical Board takes final action based upon the licensee's conviction of one or more of the offenses or the Board determines the licensee is capable of returning to practice. The bill also adds conviction of a misdemeanor involving moral turpitude to this list of grounds for suspension or revocation of a license and removes the limitations on the offenses for which the Board may employ its investigative subpoena powers. The bill has not been assigned to a committee yet. **OSMA**

Eric Burkland is Director of OSMA's Department of State Legislation





The Wright Stuff

By Karen S. Edwards

NEIL ARMSTRONG and John Glenn aren't the only links Ohio has to the national space program.

Each year, five or six physicians emerge from a program at Wright State University in Dayton with what may be all the "right stuff" for their own missions into space.

"We have the only civilian aerospace medicine program in the world," states Stanley R. Mohler, MD, who not only heads Wright State's program, but is a pilot and aviation medical examiner himself. In addition, he is currently serving as President of the Aerospace Medical Association, a group that formed as early as 1929 to "explore the medical aspects of aviation and space flight."

Wright State's program does not date back quite that far, however.

Despite the fact that public interest in the space program would not get off the ground until the late 1960s and 1970s, "the first civilian aerospace residency program actually began in the 1950s at The Ohio State University," says Dr. Mohler.

Ironically, that program disbanded in 1977 when public interest was at a fever pitch, and common sense more than anything resurrected the program and brought it to Wright State one year later.

"Wright State was really the ideal place to establish such a program," says Dr. Mohler. Certainly the school's close proximity to Wright-Patterson Air Force base, the

The Wright Stuff

continued

University's flight school and nearby air history museum must have helped officials at the National Aeronautical and Space Administration (NASA) agree to enter into a cooperative venture with the University.

The program was established in 1978, and in 1979 Wright State produced its first aerospace medicine graduates. Since then, it has produced graduates at the rate of five or six per year.

"We are beginning to see more applicants," says Mohler, who estimates that the program is now receiving 50 or 60 applications annually, "but I don't think it's because interest in space has just started to peak again. I think the interest has always been there, but until recently, no one knew anything about us. Now, however, the word is out."

And the word appears to have spread. Fledgling physician-astronauts from Canada, Mexico, Australia and Japan have already taken the program, and are at work in space programs in their respective countries.

"Our Australian graduate may very well be his country's first astronaut," notes Dr. Mohler with understandable pride.

"We will teach them not only how to fly a plane, but the space shuttle itself, if they want to learn," Dr. Mohler says. "The opportunities are there."

Since the purpose of the program is to get physicians working in space stations and in support crews on the ground, Wright State seems to have achieved at least a degree of success on an international scale. But what about nationally?

"So far, all of our residents have gone into jobs in either aviation or aerospace," says Dr. Mohler. Both NASA's Kennedy Space Center in Florida and the Johnson Space Center in Texas employ Wright State graduates, and one graduate has even served as crew flight surgeon aboard a recent shuttle.

"Our residents receive much of the same type of training as the astronauts," says Dr. Mohler.

Below: Stanley R. Mohler, MD (fourth from left) stands surrounded by medical students participating in Wright State University's aerospace medical program — the only such civilian program in the country (photo courtesy of Wright State University's Department of Communications.)



This type of training comes in the student's third-year, when their course work temporarily moves to one of the NASA space centers.

"They have the opportunity to experience weightlessness through the simulation equipment and to fly with the astronauts on some of the test flights if they want. In fact, we will teach them not only how to fly a plane, but the space shuttle itself, if they want to learn," Dr. Mohler says. "The opportunities are there."

In space or down below, however there is much work to be done.

"At the centers, our students do actual physical exams on the astronauts, and work on other projects related to the space program," explains Dr. Mohler.

Research, for example, is on-going in a number of areas.

How do you maintain physical fitness in space? Do muscle strength and strength of the bones alter in space? How does an astronaut get adequate rest? These are just some of the questions being actively examined by aerospace physicians in general — and by Wright State students in particular.

"One of our residents is working on the problem of space sickness, and has conducted tests directly on one of the subjects," says Dr. Mohler.

Other students are examining new ways to exercise in space; how proper medical treatment facilities would be outfitted for (and operate in) space; atmospheric characteristics; crash dynamics; how people can be protected during flight; and additional ways to adapt to space environment.

"For example, we've learned that, in space, many people don't feel thirsty. That's because, in a weightless environment, the fluids are staying up around their heads instead of being pulled down to their feet as they are in a gravity situation, and they just don't feel the need to take in liquids. We have to tell them that they must drink fluids — whether they are thirsty or not," explains Dr. Mohler.

Research possibilities are virtually endless.

"The whole area of aerospace medicine is going to expand," Dr.

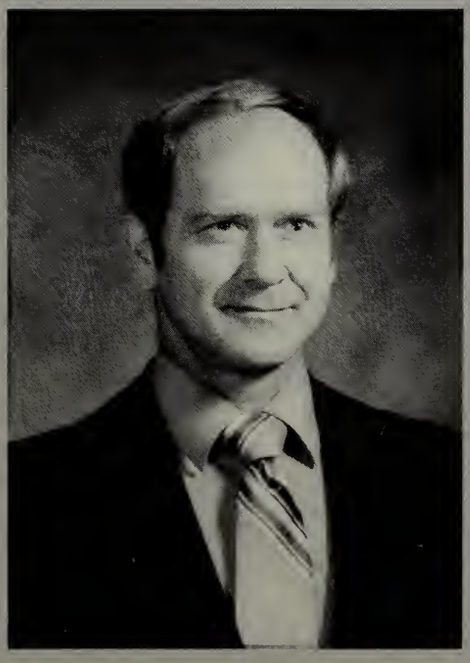
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A REMEMBERED WEIGHTLESS EXPERIENCE

Editor's Note: *During a stint as a flight surgeon for a group of test pilots and crews at Wright-Patterson Air Force Base (WPAB), David R. Rudy, MD, Columbus, was involved in "zero gravity" training for prospective astronauts. For the tests, "aircraft were equipped to fly parabolas in the verticle plane while trainees rode behind in a padded hold." For those who will never know what it's like to float in a weightless environment, Dr. Rudy recounts his experience.*

. . . The day came when I ran out of reasons to avoid the weekly flight of the "zero G" airplane. So I was obliged to suit up and board the specially-fitted C-131 (Convair 220, prop driven) at Wright Field.

The routine involved starting at an altitude of 10,000 ft. over southern Ohio, diving to gain momentum, pulling up sharply, pointing the nose into the parabolic arc, flying the arc until the nose down "attitude" produced another speed gaining dive and repeating the process twice. Three such passes would spend 5,000 ft., whereupon the aircraft would climb again to 10,000 ft. and start it all over again. Seven such runs, at three parabolas each, typically, would produce 21 passes. At C-131 speeds, each pass lasted about 22 seconds.



David R. Rudy, MD

When the pilot started the plane into its arc, he was, in effect, throwing us all through the air like a baseball, then flying around us as we passively sailed through inner space. As a check against himself, he would keep afloat a small cork in a glass bottle attached to the instrument panel.

The crew had told me with diabolical smirks that no flight surgeon had yet made it through 21 passes without motion sickness to the point of vomiting. Why we weren't all instructed to have remained NPO after midnight I didn't ask. As it turned out, weightlessness was the mildest of the assaults upon the semicircular canals offered by this type of flight. The vestibular rigors range from ½ G as the dive begins, to 2½ G at the pullup, followed quickly by the zero G phase throughout the arc with the process repeated 20 times.

The first sensation noted during the weightless phase was the rush of blood to the head as in hanging upside down on a monkey bar. The feeling that followed was as exhilarating as the astronauts say. Tumbling, darting,

continued on next page

The Wright Stuff

continued

Mohler says confidently. "I think we'll see a real opening of space in the next twenty or thirty years. We're going to explore the use of space as an energy source, for example, since during the past several decades, we've been able to locate scarce elements on some of the planets. It's hard for us to appreciate how much potential lies out there."

Certainly potential for physicians in aerospace medicine is growing.

"I would estimate that there are 200 to 300 physicians working directly in the space program now," says Dr. Mohler, "And many more than that are working in aviation."

civilian program is that participants are able to select and conduct their own research projects rather than only those which are "officially approved."

"In fact, our residents are required to have a research project, and must develop a master's thesis based on the project before they can graduate," says Dr. Mohler.

Perhaps this freedom of research partially explains the presence of military officers in Wright State's program.

But civilian or military, there seems little doubt that space looks like a good area for physicians.

"Aerospace medicine is one of 23

"The whole area of aerospace medicine is going to expand. I think we'll see a real opening of space in the next twenty or thirty years."

Besides research, physicians are needed by the Federal Aviation and Aeronautical Board to conduct physical exams for pilots, and even in the area of produce production.

"Physician input is needed by major industries on the design of space and aviation products — like the space shuttle, and transportation for the planet surface itself," says Dr. Mohler.

An interesting note is that women are as apt to participate in Wright State's program as men, though not in as large a number.

"We've had two women in the program thus far. One of them is now with the Kennedy Space Center."

So, Wright State not only has its eyes on the future — it's preparing for it. Can it do as adequate a job at training aerospace physicians as the military, which has two such programs already (the Navy operates a program at Pensacola, Florida and the Air Force at San Antonio, Texas)?

"That's like asking if Harvard can do as adequate a job educating its students as West Point," observes Dr. Mohler. "They both do good jobs, but their directions are different."

One of the advantages of the

specialties which the American Medical Association, itself, has worked to develop," says Dr. Mohler. It falls into the broad-based term of Preventive Medicine, which also includes the specialties of occupational medicine and public health."

Alvin Tarlov, MD, Chairman of the Department of Medicine at the University of Chicago (who chaired the Graduate Medical Educational National Advisory Committee at the time it released its controversial report predicting a physician surplus by 1990) says that preventive medicine is one of the few areas which will *not* be inundated with physicians in the coming decade.

Space. Whether or not it's the "final frontier," one thing is certain. Wright State University's aerospace medicine program has all the "right stuff" to ensure that men and women — on the ground or in space itself — will have all the advantages modern medicine can offer. **OSMA**

Karen S. Edwards is the Executive Editor of the Ohio State Medical Journal.

A Remembered Weightless Experience

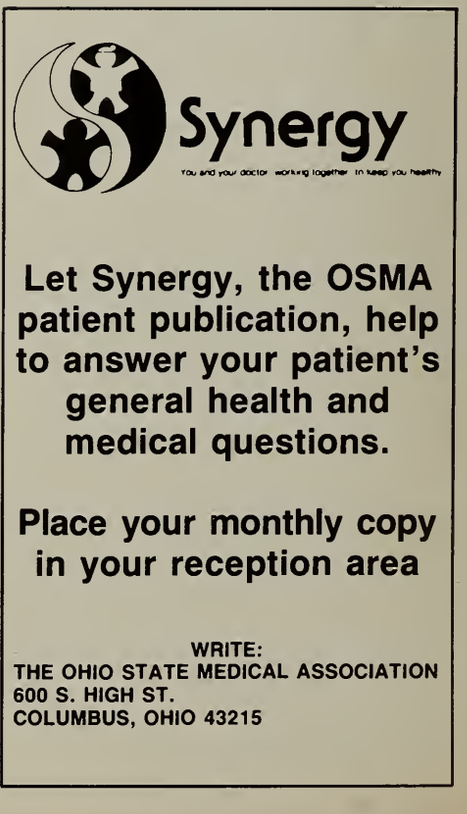
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turning, floating as in a swimming pool but without the chlorine in the nose. Helmets come in handy because of the tendency easily to forget that a tank type pushoff from a rear bulkhead brings one forward like a shot in the virtually frictionless medium.

By the 15th pass, nausea had become noticeable during the ½ G phase of the beginning of the dive. The enlisted men among the crew had been eyeing me, no doubt as to the status on their bets on my stomach's staying power. But, thanks to a hint from a kindly lieutenant, a lateral reclining position assumed for that phase took the over stimulus (of the superior semicircular canal?) and reapplied it elsewhere in the inner ear.

Thus, did the green flight surgeon survive the last six passes and enter the unofficial WPAFB record book as the first doctor to avoid nausea on a zero G flight. — *David R. Rudy, MD*

(reprinted with permission from the **Bulletin** *of the Academy of Medicine of Columbus and Franklin County.)*



Government Access to Books and Records of Medicare Subcontractors

By D. Brent Mulgrew, J.D., and Catherine C. Costello, J.D.,

Section 952 of the Omnibus Reconciliation Act of 1980 (Pub. L. No. 96-499) expanded requirements on contracts between Medicare providers, including hospitals, skilled nursing facilities, and home health agencies, and their subcontractors. The rule promulgated under the statute defines a subcontractor as any entity, including an individual, that contracts with a provider to supply service(s) to the provider or a beneficiary for which Medicare may pay the provider the cost of the services. Specifically the provision applies to contracts which:

(1) involve *services* for which Medicare payment may be made; and
(2) have a value or cost of $10,000 or more over a twelve month period.

Contracts which are "entered into" after December 5, 1980 must contain a clause permitting the Secretary of Health and Human Services (HHS), the Comptroller General (General Accounting Office), or their authorized representatives access to such "books, documents and records" as are necessary to certify the nature and extent of costs claimed. Without an approved access clause, the statute prohibits reimbursement to the provider for the costs claimed under the contract.

Section 952 also applies where a subcontractor carries out its duties through a related organization of the subcontractor (i.e., common ownership or control). Contracts between a subcontractor and a related organization must contain a comparable clause concerning access to the books, documents, and records of the related organization. The access to the books and records must be provided for four years after expiration of any contract covered. Health and Human Services (HHS) issued final regulations on December 30, 1982 which will apply to books, documents, and records relating to contracts entered into after December 5, 1980. 47 Fed. Reg. 58260.

HHS believes that most requests for review will be made by the provider's intermediary (or carrier) but HHS and the Comptroller General retain the authority to request the provider's and subcontractor's books, documents, and records. The right of access applies to books, documents, and records "necessary to verify the nature and extent of the costs of the services provided by the subcontractor." According to the Final Rule, HHS will request review *only* if one of the following situations exists and the question cannot satisfactorily and efficiently be resolved without access to the books, documents, and records:

(a) HHS has reason to believe that the costs claimed for services of the subcontractor are excessive or inappropriate;
(b) There is insufficient information to judge the appropriateness of the costs;
(c) There is a written accusation with suitable evidence against the provider or subcontractor of kickbacks, bribes, rebates, or other illegal activities; or
(d) There is evidence of a possible nondisclosure of the existence of a related organization.

A copy of the final rule is available from the Department.

The OSMA is registered as a 501 (c)(6) corporation with the Internal Revenue Service. To maintain such standing, the Association's activities must promote the common interest of the membership rather than provide specialized services to individuals. Consequently, this column will be devoted to general legal questions of interest to the membership. Suggestions for future columns may be sent to: OSMA Department of Legal Affairs.

Celeste Extends Health Care Construction Moratorium For 60 Days

On October 17, 1983, Governor Celeste extended for another 60 days the moratorium he imposed on the construction of so-called urgent medical care facilities and the purchase of high-cost medical diagnostic equipment.

The governor's executive order extending his order of July 21, 1983 gives the General Assembly through the end of 1983 to consider legislation (SB 269) that would authorize the moratorium. The construction of the urgent care facilities is not subject to the state's certificate of need (CON) review procedure.

The governor's order implements

continued on next page

temporary rules drafted by the Department of Health. The rules resulted principally from Governor Celeste's and Director David Jackson's concern about the "overbuilding" of such facilities and the possibility of that contributing to increased health care costs. The rules also limit the ability of health care facilities to make major investments in new medical equipment and also expends the state's power to review extraordinarily expensive medical procedures. (See *Ohio State Medical Journal* November, 1983, page 817)

Senate Bill 269 (Valiquette, D-Toledo) proposes a moratorium, during which time existing regulations governing the issuance of certificates of need for construction would be reviewed and guidelines developed to regulate construction of urgent care centers and ambulatory surgical centers. Those facilities currently are considered to be a doctor's office or extensions of a doctor's office and not subject to state review. Director Jackson has appointed Task Forces to consider these issues. A report is expected during 1984.

away last summer. Her term will run until March 19, 1989. Mrs. Carol Rolfes has replaced Mr. Walter Paulo as one of two consumer members on the Board. Her term will run until July 31, 1988.

This month, the column profiles Deirdre O'Connor, MD. Mrs. Rolfes will be highlighted in the February column.

Deirdre O'Connor, MD, MPH, is uniquely qualified to serve on the Ohio State Medical Board. As Medical Director of Flower Hospital's Chemical Dependency Center in Sylvania, she brings a professional approach to the problems of impaired physicians. With the board's increased emphasis on drug and alcohol rehabilitation, Dr. O'Connor's expertise will prove invaluable in disciplinary hearings.

Born in England, Deirdre O'Connor received her medical training at the Royal College of Surgeons in Dublin, Ireland. After graduating in 1956, she interned in general medicine at Flower Hospital, then obtained her Master's in Public Health from the Harvard School of Public Health.

Dr. O'Connor's previous positions include work as the Wood County Health Commissioner and as an Assistant Health Commissioner for the Cincinnati Health Department. She also staffed the walk-in clinic of St. Vincent Hospital's Emergency Room.

For the past five years, Dr. O'Connor has served as Director of Flower Hospital's Chemical Dependency Center. In this position, she has been responsible for directing an inpatient program for alcohol and drug abuse. Dr. O'Connor feels the experience which she has received working with this program will be beneficial in her role as a member of the Medical Board. Her background will enable her to evaluate the progress of licensees who are under suspension by the board for drug or alcohol abuse. **OSMA**

D. Brent Mulgrew, J.D., and Catherine Costello, J.D. are in OSMA's Department of Legal Services and serve as OSMA's Staff Counsel.



Deirdre O'Connor, MD . . . new Medical Board appointee.

Governor Fills Medical Board Vacancies

Editor's Note: *Deirdre O'Connor, MD, has been appointed to fill the unexpired term of Dr. Anthony Ruppersberg, Jr., MD, who passed*

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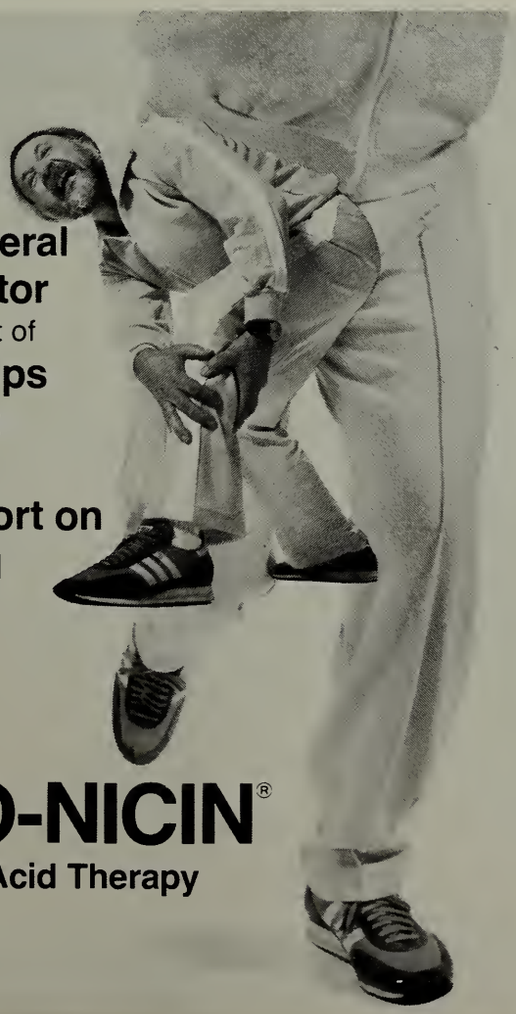
The VOA was founded in 1896 in New York City as a Christian service organization with members from all Christian denominations. Services are offered nationally. You are invited to lend a hand.

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continued on page 53



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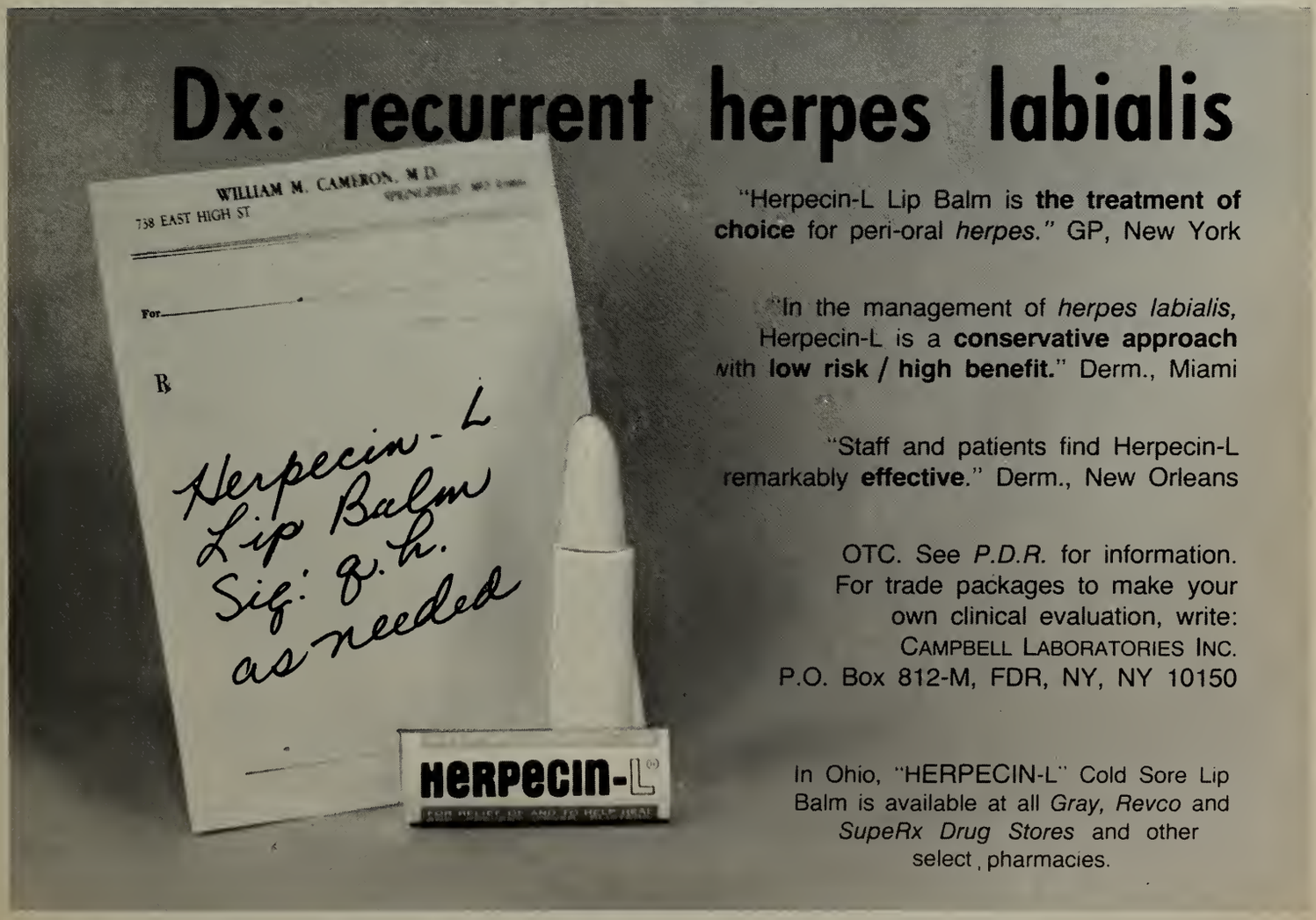
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HARRY E. CHALKER, MD, Girard; Ohio State University College of Medicine, 1924; age 85; died October 18, 1983; member OSMA and AMA.

BERNARD K. CRAW, MD, Oregon; Eclectic Medical College, Cincinnati, 1939; age 72; died October 20, 1983; member OSMA and AMA.

MARTIAL A. DEMANY, MD, Cleveland; Faculte de Medecine University de l'etat a Liege, Liege, Belgium, 1956; age 53; died September 19, 1983; member OSMA and AMA.

JOHN E. DOUGHERTY, MD, North Canton; Case Western Reserve University School of Medicine, 1934; age 77, died October 17, 1983; member OSMA and AMA.

CLETUS GROTHJAN, MD, Toledo; St. Louis University School of Medicine, St. Louis, Missouri, 1927; age 80; died November 9, 1983; member OSMA and AMA.

GEORGE E. MARR, MD, Hamilton; University of Louisville School of Medicine, Louisville, Kentucky, 1936; age 71; died October 26, 1983; member OSMA and AMA.

JOHN J. McHUGH, MD, Sylvania; University of Louisville School of Medicine, Louisville, Kentucky, 1960; age 65; died November 7, 1983; member OSMA and AMA.

JAMES L. REYCRAFT, MD, Chagrin Falls; Case Western Reserve University School of Medicine, 1915; age 92; died October 7, 1983; member OSMA and AMA.

CREED F. WARD, MD, Cleveland; Ohio State University College of Medicine, 1949; age 67; died October 27, 1983; member OSMA and AMA.

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CLINICAL NOTES

Edited by Karen S. Edwards

Psychiatric Disorders Undertreated

The majority of persons with serious psychiatric disorders may not be receiving appropriate treatment, according to E.H. Uhlenhut, MD, from the University of Chicago. Findings from his survey of 3,161 noninstitutionalized adults showed that 69% of persons with major depression and 62% of persons with generalized anxiety used no psychotherapeutic medications. "Some persons with these disorders probably never seek any sort of help," Uhlenhut writes. "Among patients who do present themselves to the medical system, usually in primary care settings, these disorders often go unrecognized."

— **Archives of General Psychiatry**
November, 1983

Enzyme In Marathoners Mimic Heart Attack

An enzyme that is widely regarded as a specific marker for heart muscle injury is also found in the blood serum and skeletal muscle of long-distance runners. A study of 25 trained marathoners showed that enzyme levels in asymptomatic runners may be due to a continuous cycle of skeletal muscle injury and repair, speculates Arthur J. Siegel, MD, currently at Hahnemann Hospital, Brighton, Mass. High enzyme levels in both skeletal muscle and serum after competition suggest that the source is skeletal rather than heart muscle, he writes.

— **Journal of the American Medical Association**
November 25, 1983

AILD In Aids

A report describes two cases of angioimmunoblastic lymphadenopathy with dysproteinemia (AILD) occurring in homosexual men with symptoms of acquired immune deficiency syndrome (AIDS). "The immune system is somehow defective in both entities," say Walter Blumenfeld, MD, and Jay H. Beckstead, MD, from the University of California School of Medicine, San Francisco. The two diseases share many clinical and laboratory findings, but the relationship between them remains to be elucidated. "AILD may be one additional manifestation of AIDS in a subset of patients with that disorder," the authors say.

— Archives of Pathology and Laboratory Medicine
November, 1983

BIOFEEDBACK EFFECTIVE AGAINST HEADACHES

Biofeedback is an established adjunct to treatment of headaches, particularly those of vascular origin, according to a report from the AMA Diagnostic and Therapeutic Technology Assessment (DATTA) program. The DATTA panel of experts uniformly judged biofeedback to be safe, citing its lack of side effects, and noted that it can reduce the need for medications, can be easily used in the home setting and can help encourage the patient's active participation in therapy. Negative aspects include the need for specialized training and frequent retraining of the patient, poor long-term compliance and the tendency of some practitioners to present biofeedback as a "cure-all" for all problems.

— Journal of the American Medical Association
October 31, 1983

SNUFF DIPPER'S CARCINOMA

People who think that chewing tobacco is safer than smoking it are harboring a dangerous notion, says W. Frederick McGuirt, MD. His study at the Bowman Gray School of Medicine, Winston-Salem, NC, of 290 patients with oral tumors showed that 57 chewed snuff exclusive of any use of cigarettes, pipes or alcohol. They were primarily white women older than 60 years who had "dipped" snuff longer than 40 years. More than 49% died of their disease or of complications of treatment (surgery, radiation), and only about 25% were alive and free of disease after five years. A popular shift from smoked to smokeless tobacco will merely result in a change in the site of tobacco-related cancer, McGuirt warns.

— Archives of Otolaryngology
November, 1983

Blindness In Newborns

The increased survival of low birth weight infants has resulted in a greater incidence of retrolental fibroplasia, a form of eye damage that can lead to visual disturbances and blindness. Associated with the use of high concentrations of oxygen, the condition is limited primarily to premature infants weighing less than 1,500 g. at birth, according to physicians at Indiana University Hospitals, Indianapolis. Infants who require mechanically assisted ventilation because of respiratory distress are at greater risk for developing this complication, they say, and there seems no way to prevent it.

— **Archives of Ophthalmology**
November, 1983



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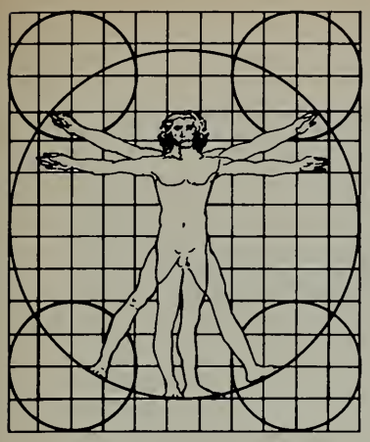
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CLINICAL & SCIENTIFIC

RADIAL PULSE ASSESSMENT OF BLOOD PRESSURE (RPBP)

Charles T. Wehby, MD
John H. Wehby, MD

The capability of assessing blood pressure from the radial pulse is herewith presented. It allows the patient to actually read the finding and promotes interest in responding to methods of management. Using the methodology described, it is possible for the first time for the average person, deaf and extremely obese individuals to easily monitor their own blood pressure. The role of centralized pressure in realizing this potentiality also is discussed.

Since hypertension, and its attendant effects, represents one of the most important causes of death, it is natural that interest is profound in its detection, cause, prevention and therapeusis. The detection of hypertension is relatively easy, but the other desires are difficult, hence our problem is not strategic, but tactical. Now detection is a long way from cure, but it is of prime importance in encouraging patients to cooperate in known methods for management. Hence, the purpose of this paper, i.e. a method to allow the patient to actually monitor his own blood pressure, under the guidance of his physician, by noting the absence, presence or variations in his radial pulse (RPBP). This capability derives from a concept originally contributed by me in *The Ohio State Medical Journal* (1973) under the title of Centralized Pressure in Sphygmomanometry and featured in The Ohio State Medical Convention in 1980.[1]

It will be recalled that the most important capability of centralized pressure was the physician's ability to monitor blood pressure on *inflation* and *deflation.* These modalities were possible because of the silence and controlled inflation, and resulted in less trauma to the patient, since unnecessarily high inflation was avoided as was experienced with the time-honored method of blood pressure determination. Another feature of this approach, noted by us in years of use of this method, was the palpable response of the radial pulse in the maneuver. Predictably, the pulse disappeared when the pressure rose above the systolic pressure; it returned at the exact systolic pressure and changed perceptibly on diastolic, as detected by palpation. *Indeed, here was a method to detect blood pressure by palpation of the radial artery instead of auscultation by the brachial artery.* It also was noted that the blood pressure was reflected accurately by auscultation over the radial instead of the brachial artery. This was especially valuable in extremely obese people where the cuff was applied on the forearm instead of the conventional area. Palpation of the radial artery in this instance also reflected the blood pressure accurately. Incidentally, deaf individuals and, in fact, anyone can determine their own blood pressure with this technique. The value of this concept to anesthesiologists is obvious.

Technique

Since patient awareness and interest are of vital importance for cooperation in hypertension, we have allowed patients to visually substantiate the reading of their blood pressure by the following technique: After the blood pressure has been ascertained by the physician and revealed to the patient, have the individual gently place the second and third fingers of the right hand over the left radial artery until he or she notes the maximum intensity of the radial pulse. Tell the patient to note when the pulse disappears, as the cuff is gradually inflated (which can only be achieved accurately with controlled centralized pressure). Then explain that this represents their systolic pressure and its significance; subsequently, allow the pressure to decrease and have them note when the pulse reappears and continue to diminish the pressure until a slight decrease in volume of the radial pulse is noted. Explain that this represents their diastolic pressure and its significance. Incidentally, with conventional blood pressure determination, similar results can be achieved, but only on *deflation* and a discrepancy of four to six mm of Hg. due to palpatory as against auscultatory perception must be considered.

Conclusion

The psychological effect of proving the presence or absence and degree of improvement in a hypertensive patient has been considerable and enhances patients' awareness and cooperation. This extrapolation of a known entity to improve patients' health is, we feel, a worthy contribution to medical diagnosis and management.

Conceivably, this concept assuages Thomas Gray's lament in his famous elegy: "Full many a flower was born to blush unseen and to waste its sweetness on the desert air."

Dr. Charles T. Wehby, Cincinnati. Deceased. Formerly general practitioner and Senior Medical Attending Physician, Good Samaritan Hospital.
Dr. John H. Wehby, Cincinnati, family practitioner and associate medical attending physician, Good Samaritan Hospital.
Submitted May 17, 1982

Reference

1. Wehby, Charles T.: Centralized Pressure in Sphygmomanometry. *The Ohio State Medical Journal*, Vol. 69, pages 125-127, February, 1973.

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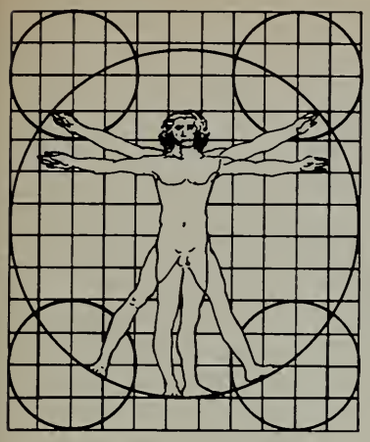
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CLINICAL & SCIENTIFIC

USE OF KETOCONAZOLE IN THE MANAGEMENT OF COMMON CUTANEOUS MYCOSES

Paul G. Hazen, MD
Donald J. Blaney, MD
Milford E. Gottlob, MD
James M. Marrs, MD
Robert C. Rau, MD
Frank W. Yoder, MD

Fifty-two patients having a variety of cutaneous fungal infections were treated with ketoconazole, a new antifungal agent. All patients were seen in routine outpatient dermatologic practices throughout the state of Ohio. The drug was shown to be markedly effective in all infections treated, with cure rates after 30 days of therapy of 90.9% in tinea cruris, 83.3% in tinea corporis, 75% in tinea pedis, and 100% in tinea versicolor and cutaneous candidiasis. Two patients who were apparently cured at the end of the treatment course subsequently relapsed within three months after stopping the drug. Side effects were minimal in this study, although liver function abnormalities have been reported in other series of patients.

Introduction

CUTANEOUS FUNGAL INFECTIONS represent a common management problem in clinical dermatologic, pediatric, family practice, and internal medicine practices. Although a variety of topical therapies are available, no one agent has been uniformly useful for the majority of infections affecting the skin. The imidazole compound ketoconazole has recently been shown to be effective in managing many patients with superficial and deep fungal infections, including histoplasmosis, candiduria, candidiasis, chronic mucocutaneous candidiasis, coccidioidomycosis, paracoccidioidomycosis, chromomycosis and blastomycosis. These results suggested ketoconazole might also be effective in managing the more common cutaneous mycoses: dermatophytosis, cutaneous candidiasis, and tinea versicolor.

From the Departments of Dermatology at Case Western Reserve University (Drs. Hazen and Gottlob), Ohio State University (Drs. Rau and Yoder) and The University of Cincinnati (Drs. Blaney and Marrs).
Submitted: October 19, 1982.

This report details the results of six dermatologists based in clinical practices in the Cleveland, Columbus, and Cincinnati areas of Ohio using only ketoconazole to manage acute and chronic cutaneous fungal infections.

Methods and Materials

All patients were those seen at the offices of six dermatologists in various locations in Ohio. All had cutaneous fungal infections caused by either dermatophytes, *candida albicans* or *malassezia furfur (pityrosporum orbiculare)*. Diagnosis was confirmed either by microscopic identification of hyphal structures by skin scraping or through fungal culture. Infections were determined to be either acute (with oozing, vesicles, inflammation, or severe itching) or chronic.

After informed consent was obtained, all patients were given ketoconazole 200 mg tablets and asked to take one tablet daily with food. It was requested that a diary be kept detailing progress of the infection and possible side effects. After 30 days, all patients were examined and scrapings for microscopic examination or cultures were taken from the previously affected areas. Patients were classified as either being cured (no KOH or clinical evidence of infection), markedly improved, moderately improved, minimally improved or unchanged.

Results

Forty-seven patients completed the study. An additional three patients failed to return; one patient never took the medication; one patient dropped out of the study after two pills because of gastrointestinal upset. Four patients had two sites of infection.

Patients in all categories of infection demonstrated improvement at the day 30 visit (see Table). Overall, 36 of 47 (76.7%) of the patients were cured, eight were markedly improved (17.7%) and three were moderately improved (6%). Scraping for fungus was negative in 45/51 (88.2%) of patients. In general, patients with acute fungal infections had a higher rate of clearing (11/11-100%) than those with chronic infections (26/36-72.2%).

There was no difference in the response rate of men versus women and no age-related differences were noted. Patients with candida, tinea cruris and tinea corporis noted improvement slightly more quickly than those patients with tinea versicolor, pedis or manum infections.

Discussion

Treating of the cutaneous mycoses is a common and often difficult problem facing clinicians. Although multiple topical

agents exist, there are relatively few systemic agents available. Furthermore toxicity of the systemic agents has limited their usefulness. We now report our experience with a new oral antifungal agent, ketoconazole, in the management of cutaneous mycoses.

In general, mycoses primarily affecting skin may be divided into three major groups: dermatophyte (*trichophyton, epidermophyton* and *microsporum* species), candida (primarily *candida albicans)* and *malassezia furfur.* These agents are responsible for causing 1) tinea corporis, pedis, cruris, capitis, barbae and unguium, 2) thrush and moniliasis and 3) tinea versicolor respectively. Although all are common cutaneous mycoses, no single systemic medication has until now been practical to use for all three of these processes.

Griseofulvin, in use since the 1950s, is effective in managing many patients with dermatophyte infections.[2] It is, however, ineffective in patients with monilia or tinea versicolor. Furthermore, side effects such as nausea, headaches, blood dyscrasias, liver toxicity and alteration of anticoagulant effect are common.[3] Also, many patients with chronic fungal infections or those with nail involvement often have infections unresponsive to griseofulvin.[4]

Amphotericin B is effective against all three cutaneous mycoses. Its toxicities and difficulty of administration make this an impractical therapy for most patients, however.[5]

Topical agents such as haloprogin,[6] miconazole,[7] and clotrimazole[8] have anti-dermatophyte, and anti-candidal activity and are also effective in tinea versicolor. However, in extensive infections or in areas where the organisms may be sequestered (such as in paronychial, nail, or follicular regions) use of topical agents alone may be impractical or ineffective.

Ketoconazole, an imidazole compound, is a new oral antifungal agent. It is thought to work by interfering with ergosterol production in the cell wall of a wide variety of fungi.[9] Its *in vitro* effectiveness, at least against candida, is improved by interraction with polymorphonuclear leukocytes.[10] It is presently approved for use in treating the following systemic fungal infections: candiduria, chronic mucocutaneous candidiasis, oral thrush, candidiasis, coccidioidomycosis, blastomycosis, histoplasmosis, chromomycosis and paracoccidioidomycosis. It is still considered investigational for use in dermatophytic infections.

As demonstrated in our study, ketoconazole appears to be effective against all three commonly occurring cutaneous mycoses. Subjective and objective improvement was noted within two weeks of therapy in virtually all patients with acute and chronic infections.

Clinical and mycological evidence of cure was noted in 100% of patients with acute infections after 30 days of treatment and in 72.2% of patients with chronic infections. It also appeared to be markedly effective in managing tinea versicolor and a single patient with candidiasis. Only two patients who were apparently cured were observed to relapse in follow-up after three months. One patient each had tinea corporis and tinea cruris. Jones et al, however, reported a relapse rate of 75% in their patients after ketoconazole therapy.[11] Our much lower incidence may reflect the milder, more limited infections in our patients. These results compare with a relapse rate reported for griseofulvin of 43%.[12]

Adverse reactions were noted in 13 patients in our study. Three were felt unrelated to drug therapy; others included stomach upset in six patients (12.7%), and slight transient itching, a temporary flare of gout, mild softening of the stool and slight drowsiness in one patient each. One patient with a long history of GI intolerance to medications experienced gastrointestinal upset after two doses of the drug, requiring withdrawal from the study.

Side effects which have been reported by others include nausea and vomiting in 3% of patients, abdominal pain in 1.2% of patients, pruritus in 1.5% of patients and (rarely) headache, dizziness, fever, chills, photophobia, diarrhea, gynecomastia and jaundice.[1,13]

At the time our study was carried out, laboratory abnormalities had not been reported. Liver function tests were therefore not done. Since completion of our study, however, transient liver function abnormalities with hyperbilirubinemia has been reported in a total of 34 patients taking ketoconazole.[14-20] This has occurred as early as two weeks or as late as twenty-four weeks after starting therapy and did not appear to be dose-related. Except for one person, all patients had liver enzyme values return to normal either with cessation of drug therapy or with continued treatment. It has been estimated that the incidence of hepatocellular dysfunction is approximately 1 in 10,000. Patients with onychomycosis or a previous history of hepatitis, drug idiosyncracy or griseofulvin treatment may be at greater risk of developing this complication.[19] Women, particularly in the 40 to 60 year age group, have been affected roughly twice as frequently as males. Virtually all patients affected have noted symptoms of liver dysfunction including anorexia, nausea, vomiting, abdominal pain, jaundice, interus and dark urine.[20]

RESULTS:

TABLE: Summary of evaluable patients treated with ketoconazole

	#OF PTS	SEX F	M	AVG AGE (YRS)	AVG TIME TO CLEAR (DAYS)	PTS CLEAR@ 30 DAYS −#(%)	PTS IMPROVED @ 30 DAYS −#(%)
T. versicolor	20	3	17	29.8	19.7	20(100)	20(100)
T. cruris	11	1	10	36.6	12.8	10(90.0)	11(100)
T. pedis	8	0	8	39.4	21	6(75)	8(100)
T. corporis	6	1	5	56.3	14	5(83.3)	6(100)
T. manum	5	0	5	36	25.7	3(60)	5(100)
Candida	1	0	1	35	5	1(100)	1(100)
Total	51	5	46			45	

Note: 4 patients had infections in two regions: T pedis and manum (2 patients), T. manum and cruris (1 patient), and T. corporis and cruris (1 patient).

Four deaths have been reported in patients receiving ketoconazole, although the relationship of drug ingestion to the patient's death is highly questionable in three of these patients. A single patient has recently been reported in whom progressive liver necrosis occurred 10 weeks after starting ketoconazole 200 mg daily for onychomycosis. The total duration of ketoconazole therapy and when the drug was discontinued were not revealed. Two patients with malignancies and a single patient with systemic lupus erythematous and aplastic anemia have also died. All these patients were seriously ill and receiving multiple other medications as well.[19]

In summary, a combined experience of six Ohio dermatologists in managing cutaneous fungal infections with a one-month course of ketoconazole is presented. The drug was shown to be highly effective in clearing cutaneous dermatophyte, candida and tinea versicolor infections and to cause few side effects. Hepatotoxicity, although rare, can occur. Therefore, the appearance of symptoms of liver dysfunction should necessitate immediate cessation of drug therapy and evaluation of liver function.

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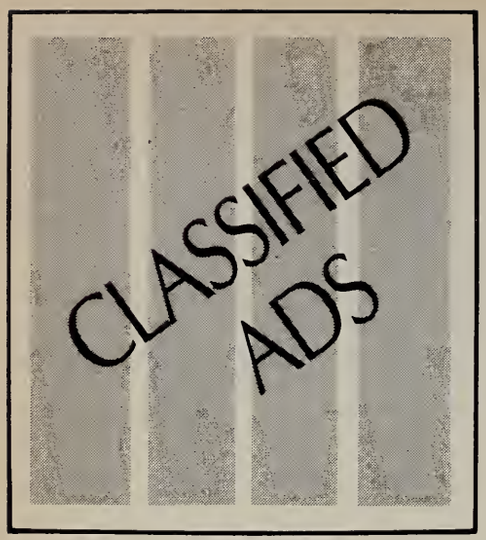
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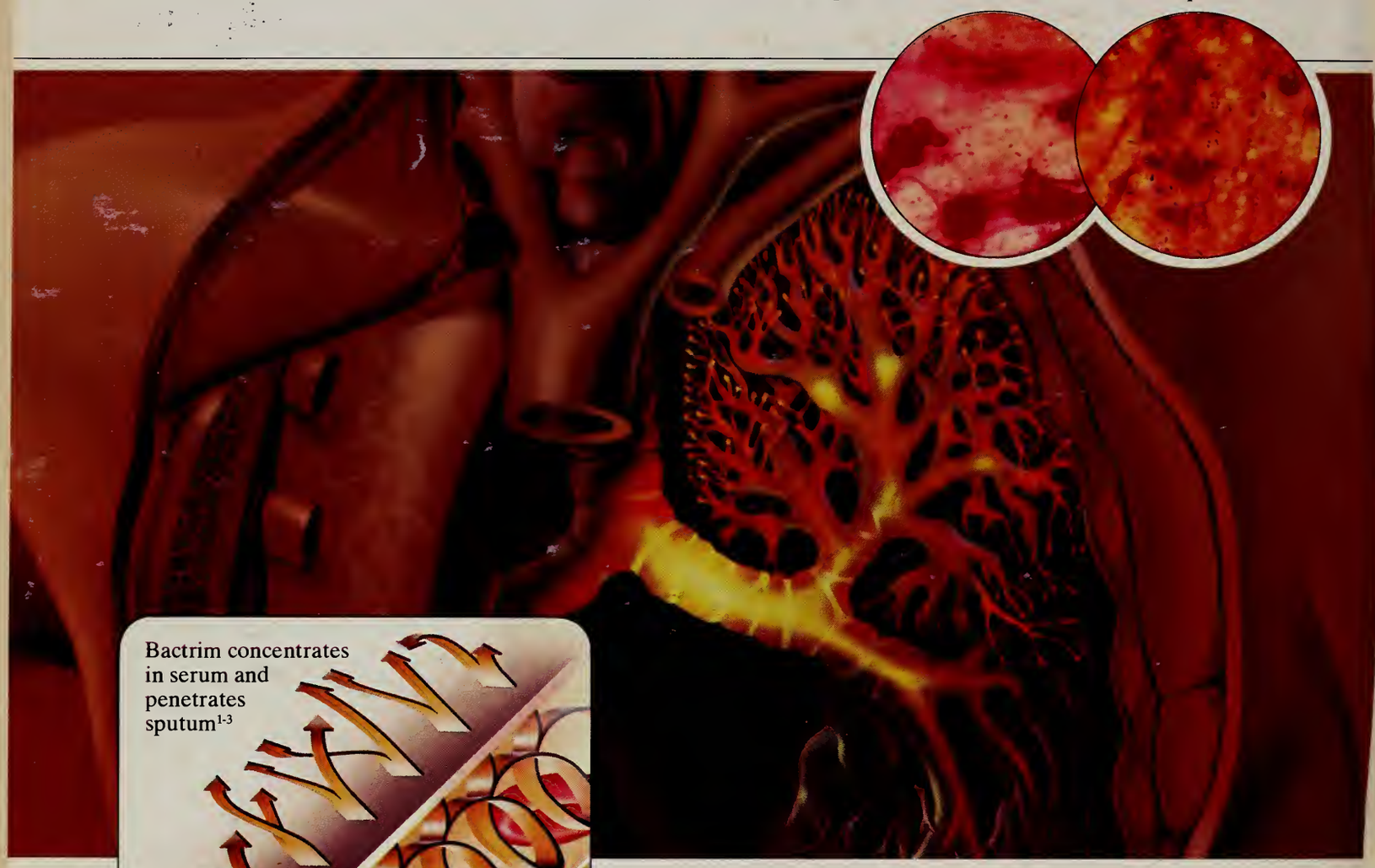
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Bactrim is contraindicated in pregnancy at term and nursing mothers, infants under two months of age, patients with documented megaloblastic anemia due to folate deficiency and those hypersensitive to either component.

References: 1. Hughes DTD, Bye A, Hodder P: *Adv Antimicrob Antineoplastic Chemother 1/2*:1105-1106, 1971. **2.** Jordan GW *et al*: *Can Med Assoc J 112*:91S-95S, Jun 14, 1975. **3.** Beck H, Pechere JC: *Prog Antimicrob Anticancer Chemother 1*:663-667, 1969. **4.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Bactrim is indicated in acute exacerbations of chronic bronchitis in adults due to susceptible *H. influenzae* or *S. pneumoniae* when it offers an advantage over single-agent drugs.

Bactrim is contraindicated in pregnancy at term and nursing mothers, hypersensitivity to either component, documented megaloblastic anemia due to folate deficiency and infants under two months of age.

References 1. Medici TC: Trimethoprim-sulfamethoxazole (Bactrim™) in treating acute exacerbations of chronic bronchitis: summary of European clinical experience, in *Chronic Bronchitis and Its Acute Exacerbations,* edited by Chodosh S; Princeton Junction, NJ, Communications for Medical Education, 1980, pp. 13-14. *2.* Dulfano MJ: Trimethoprim-sulfamethoxazole vs. ampicillin in the treatment of acute exacerbations of chronic bronchitis, *Ibid.,* pp. 19-20. *3.* Chodosh S: Treatment of acute exacerbations of chronic bronchitis: results of a double-blind crossover clinical trial, *Ibid.,* pp. 15-16. *4.* Chervinsky P: Double-blind comparisons between trimethoprim-sulfamethoxazole (Bactrim™) and ampicillin in the treatment of bronchitis exacerbations, *Ibid.,* pp. 17-18.

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For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

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Dosage: *Not recommended for infants less than two months of age.*

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Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

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Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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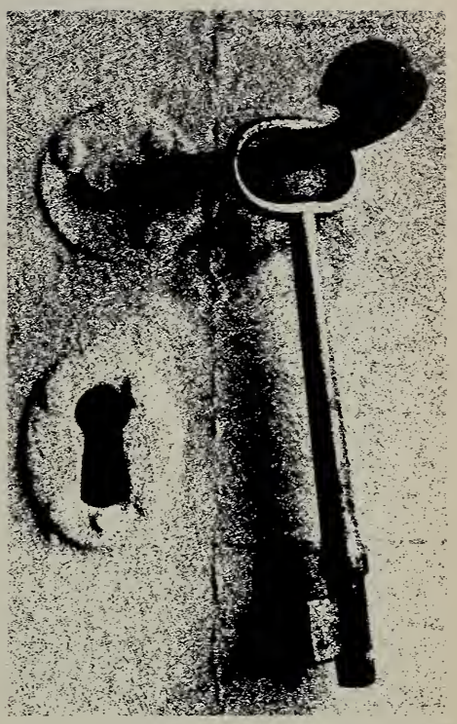
1984 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

THE Ohio STATE Medical Journal
(ISSN 0030-1124)



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The inkblot on the cover was designed by Carol Wright Mullinax, Associate Director, OSMA Department of Communications.

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Mental Health

It's worth talking about

Mental Health. There was a time when one simply didn't utter those words in polite society. Now, with controversies flaring up over such issues as deinstitutionalization, group homes, electric shock therapy, and the insanity plea, mental health has not only come out of the closet, it has become a veritable hotbed of public debate.

In this issue of the *Journal*, we take a look at the subject of mental health and at some of the controversies which surround it.

Certainly, deinstitutionalization merits a look. As more and more time has passed since the process of deinstitutionalization began, many health professionals are beginning to have second and third thoughts about the way the process is going.

In the December 19 issue of *Time* magazine, the Department of Health and Human services estimates that there are now more than 2 million homeless on the streets, the largest number since the great Depression. At least one-third of these are mentally ill, most having been released from mental institutions within the past decade.

"Deinstitutionalization was a good, civil libertarian idea," says John Talbott, MD, President-Elect of the American Psychiatric Association in the *Time* article. "The trouble was that city and state governments failed to set up a safety net for those who don't cope well."

In an article in *USA Today*, other statistics are provided.

"Two years ago, the Census Bureau counted 50,794 homeless people. Now the National Coalition for the Homeless, an advocacy group, estimates there are 2.5 million. Many of these have a history of mental problems, of psychiatric hospitalization, of alcoholism and drug abuse. Twenty years ago, they would have been hospitalized. But the trend now is against 'warehousing' the mentally ill," says an editorial on "Street People" in the issue.

The problems that are resulting from deinstitutionalization are causing many experts to sit back and reevaluate.

Robert McDevitt, MD, a Cincinnati psychiatrist, and Leslie Whitmire, MD, a Toledo psychiatrist, both examine the issue of deinstitutionalization, and how it is faring in Ohio, especially with Orient State Institute closing its doors. John Davis, MD, a Columbus psychiatrist, looks at it from the state's point of view.

"Deinstitutionalization was a good, civil libertarian idea. The trouble was that city and state governments failed to set up a safety net for those who don't cope well."

An interesting sidenote is that Ohio recently received a federal grant to study the connection between the homeless and the mental health system, a story we hope to follow up on in a subsequent issue.

Another factor that merits study — especially since the advent of deinstitutionalization — is the prison population.

In "Mental Health Behind Bars," Melvyn Nizny, MD, another Cincinnati psychiatrist, tells of a study he completed in the 1970s which looks at the mental health of inmates in an Ohio jail population and the effect of incarceration on them. The study makes interesting reading, as does the second part of the story which examines how deinstitutionalization has affected Ohio's prison and jail communities since then.

Marketing mental health services has become another big issue, as a result of deinstitutionalization, and we examine that phenomenon, as well as the more clinical subjects of "New Treatments for the Mentally Ill," and "When to Refer to a Psychiatrist." For good measure, we include an article on the OSMA's Impaired Professional Program, as patients are not the only ones struggling with the pressures and tensions leading to a breakdown of mental health.

There are no answers contained within these pages, but we hope by opening up the subject of mental health to the medical community, we can alert you to some of the problems that are taking place, how they will affect you, directly or indirectly, in your practice, and what you can or cannot do about them.

Mental Health. Like the general public, we feel it's a subject worth talking about.

— *Karen S. Edwards*

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Letters to the editor

Is It Good . . . or Is It Cost-Effective?

To the Editor:

The report, "Routine Realtime Ultrasound in a Private Obstetrical Practice" (79:714, September 1983) illustrates one of the reasons medicine is under intense public scrutiny these days. The author describes findings in 15,000 office fetal ultrasound examinations done in a private group obstetrical practice. One congenital anomaly was found for every 750 tests, with two cases missed. Breech presentations, some of which would have been evident clinically, were identified in 5.6% of patients at 32 weeks gestation and 4% at term. The gender of the fetus was identified with 98.5% accuracy in the 75% of cases where prediction was possible. Some psychological benefits were apparent.

In earlier years, the response to such data would have been, "Ultrasound is good; every gravida should have it." Now, in an era when the cost of health care exceeds 10% of the gross national product, much more than we pay for national defense, the only rational reply is, "Ultrasound is good, but is it cost-effective?" or, to be more specific, "Under what clinical circumstances can the cost be justified?"

The medical profession has a long tradition of providing the best possible care without respect to cost. The time is coming when this will no longer be economically or politically possible. Our challenge is to learn how to be more responsive to the new realities without sacrificing quality of care. We had better start addressing this painful issue realistically before we lose the power to influence the future.

Sincerely,

Robert D. Gillette, M.D.
Associate Professor
Department of Family Medicine
University of Cincinnati Medical Center

Emergency Air Transport Not Covered

To the Editor:

I read with interest the article "By land or by air?" (October '83), particularly since St. Vincent's Life Flight had recently transported my critically ill daughter from Sandusky to Akron Children's Hospital. The professionalism of the crew was superb.

However, I later found that my Blue Cross coverage through my county medical society specifically excludes any non-surface transportation. I would hope that my colleagues in Ohio become aware of this particular serious omission and attempt to correct the problem where possible. I would especially hope that physician organizations strive to keep their own policies up to date in regards to these innovations in medical care.

Sincerely,
Jeffrey A. Duffey, MD
Canal Fulton, Ohio

Three Cheers — or More

To the Editor:

About one year ago most of Ohio's county medical societies started programs to provide medical care to our citizens who were newly unemployed. Some of these programs are quite elaborate, others are less so. All are successful in meeting this special need; and, to my knowledge, none have generated rancor or objections. Most of these programs involve not only doctors, but nurses, pharmacists, hospital people, pastors, and other community leaders as well.

Now, I doff my hat to these unsung women and men who work together so well to assist their neighbors in need without the "help" of the Federal or State government. I am proud to see my colleagues function so effectively. Since I cannot commend each of them personally, I hope that this letter will suffice. I know that none of my remarks can surpass the gratitude of the recipients of this service.

C. Douglass Ford, MD
Toledo
Immediate Past-President
OSMA

Addendum

Last month, A Second Opinion titled "The Status Quo Is No Longer an Option," by Jack Methany, MD, ran without a credit line. For the record, Dr. Methany is a member of OSMA's Committee on Cost Effectiveness, and practices medicine in Woodsfield, Ohio.

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Eating Disorders: Physical or Psychological Starvation?

By Ralph Fried, MD

If history has taught us anything, it has taught us that our environment is as responsible for the way we eat as our own tastes and hungers.

This point was recently brought out at a symposium given by the Free Clinic of Cleveland on "Women and Eating Disorders" — and the fact is we, as physicians, have to recognize the truth of this statement before we can successfully take care of those of our patients who are troubled by such eating disorders as overeating, and its opposite problem — anorexia nervosa and bulimia.

As food takes on greater or lesser importance through history, we see the population responding in kind. In the 16th century, overeating was a sign of wealth — even royalty, if one considers Holbein's depiction of a grossly overweight Henry VIII. The obese person was idealized by a population happy just to be obtaining enough food for bare existence.

Even into the nineteenth century, food continued to be important — especially to the wave of immigrants who swept into the country seeking a better life. For them, the badge of success came to be the ability to set a "good table." Food was the universal panacea, the source of family unity, pleasure, and recreation.

Now, we find ourselves a nation of overweights, trying hard to fit into a new, trim image that began with the flappers, and has progressed to even slimmer ideals.

Films, television, radio and printed journals exhort us to be slim for good health, fashion, beauty and success. It is correct to say that obese individuals do suffer discrimination in employment, in admission to graduate schools and in their social life. But the quest for the ideal body has brought about its own problems.

It is correct to say that obese individuals do suffer discrimination in employment, in admission to graduate schools and in their social life. But the quest for the ideal body has brought about its own problems.

Besides the fact that it has created a billion dollar industry, including exercise salons, diet books and bariatric clinics, the pressure to be slim has developed a whole new set of eating disorders — especially among today's young females. Bingeing, emesis and catharsis are recent results of this increasing pressure.

Also, eating disorders can be an occupational hazard. George Balanchine, the late ballet choreographer, idealized the ballerina who was 5' 7" weighed 95 pounds, and was breastless, hipless and flexible. This image was so coveted by the women of the ballet — and to some extent by the male dancers — that starvation, anorexia and bulimia are not uncommon ailments in this profession.

Speaking from a political standpoint, the economy is certainly a major factor in human nutrition. High unemployment — or even under-employment, such as in the current recession — not only deprives families of optimal food, but the loss of morale and self-esteem, prompting a variety of responses from anorexia to hyperphagia and alcohol and drug abuse.

The increased isolation of modern life can also affect our style of living — and eating. The intrusion of the electronic media has cut interpersonal communications to a minimum. Easy mobility causes families to be separated geographically. The closeness of the extended family no longer exists. Our preference in dress, fashion and food is the result of Madison Avenue hype.

As physicians, we must recognize

continued on next page

Eating Disorders

continued

that eating disorders have less to do with diet and exercise than with behavioral problems. Environmental factors are primary in molding our behavior. Emphasis on being slim may be important — important for physical health and important for self-esteem and material success — but concentration on eating (whether too much or too little) can be a pivotal center of stress triggering other problems, too numerous to mention.
OSMA

Ralph Fried, MD, practices medicine in Cleveland, Ohio.

"Second Opinion" is a column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy.

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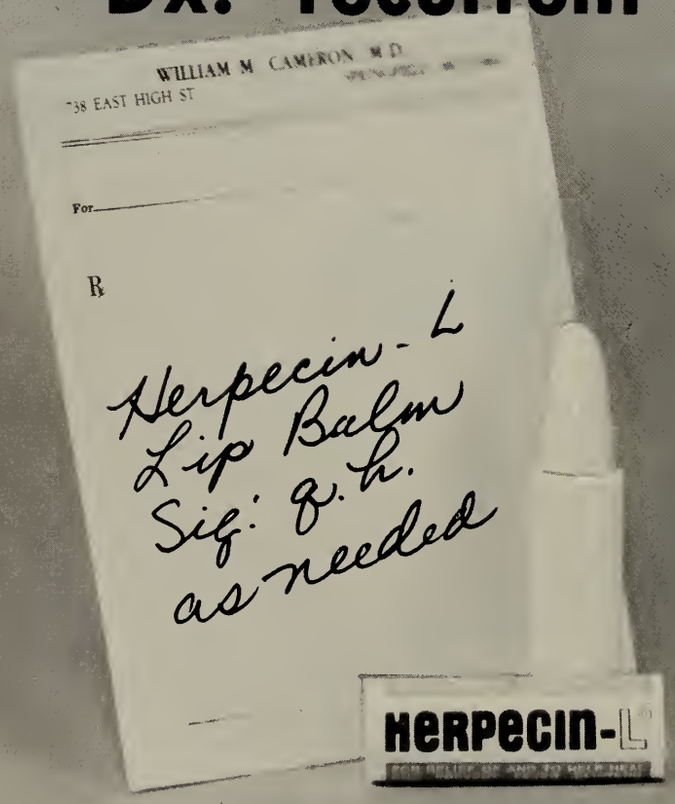
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Colleagues In The News

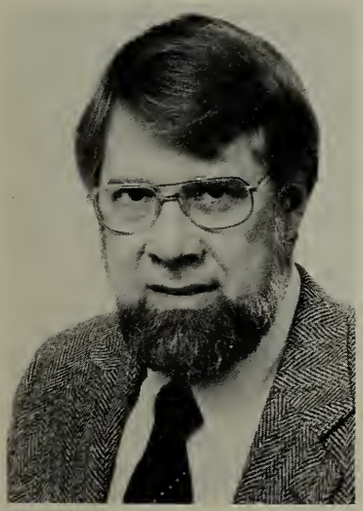
Edited by Ginny Strawser

ROBERT J. AILES, MD, Sandusky, has been appointed clinical assistant professor in the Department of Family Medicine at the Medical College of Ohio in Toledo.

JUAN CARDENAS, MD, Columbus, was elected to fellowship in the American Academy of Pediatrics. Dr. Cardenas currently serves as clinical assistant professor at the Ohio State University.

JOHN A. DeVANY, MD, Toledo, was recently appointed by Governor Celeste to the State Health Coordinating Council (SHCC). The council advises the State Health Planning and Development Agency (SHPDA).

MORRIS E. EIGENFELD, MD, was presented the Physician of the Year Award at Suburban Community Hospital. Dr. Eigenfeld has been with Suburban Community Hospital since 1957.



David L. Garver, MD

Cincinnati's Medical Researcher of the Year

DAVID L. GARVER, MD, Cincinnati, who has served as group leader of a team performing clinical and laboratory psychiatric research, has been named Greater Cincinnati's medical researcher of the year. The award was presented to Dr. Garver by the Cincinnati Coalition of Persons with Disabilities (CCPD) and Blue Cross and Blue Shield of Southwest Ohio.

SAMUEL D. GOLDBERG, MD, Youngstown, recently was awarded "Doctor of the Year" for his outstanding accomplishments in medicine and active service to the community. Dr. Goldberg is a charter member of the American Academy of Family Physicians and currently serves a fifth year on the Board of Health. Goldberg has also practiced family medicine for 47 years.

RODNEY B. HURL, MD, Columbus, will be a new member of the Union County Community Mental Health Board.

LEROY W. MATTHEWS, MD, Cleveland, was awarded the first Maurice Saltzman Award at dedication ceremonies for Mount Sinai Medical Center's new acute care building. Dr. Matthews is a pediatrics professor at Case Western University and the director of laboratories at Rainbow Babies' and Children's Hospital.

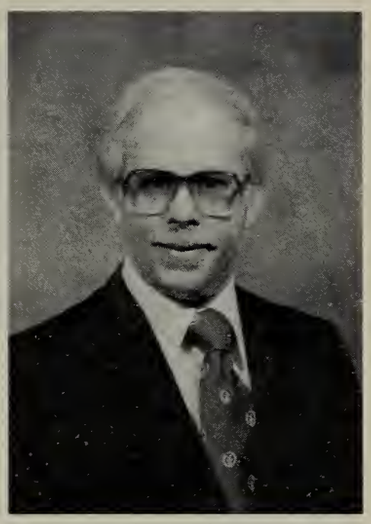
WALLACE RUSSELL, MD, Middleburg Heights, has recently accepted the position of Medical Director at Southwest General Hospital's Same Day Surgery Center.

WILLIAM SAUNDERS, MD, Columbus, recently became president-elect of the American Laryngological, Rhinological and Otological Society.

DAVID SCHULLER, MD, Columbus, received an Honor Award from the American Academy of Otolaryngology — Head and Neck Surgery — for his outstanding contributions to the academy.

S.S. STRASSMAN, MD, Cleveland, received a recognition award from the Section on Adolescent Health, for his distinguished service as Program Chairman. The award was presented to Dr. Strassman during the section business meeting in San Francisco.

PAUL J. STUEBER, MD, Cleveland, was one of the 13 new trustees elected to the Lutheran Medical Center Foundation Board.

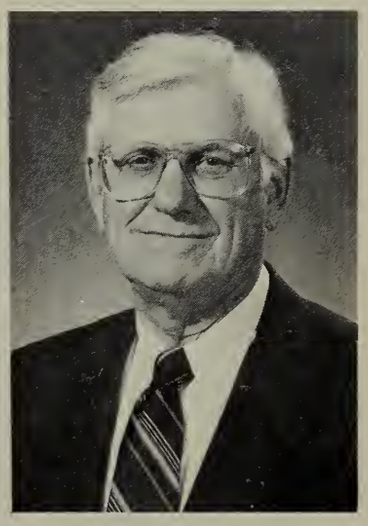


James Tennenbaum, MD

New Treasurer Named

JAMES I. TENNENBAUM, MD, Columbus, has been elected treasurer of the American Association for Clinical Immunology and Allergy. Dr. Tennenbaum was also re-appointed an Associate Editor of *Immunology and Allergy Practice.*

JAMES M. TYTKO, MD, Dayton, has been named Director of Family Services at St. Elizabeth Hospital.



Donald J. Vincent, MD

Library Named in Honor of Columbus Physician

DONALD J. VINCENT, MD, Columbus, was recently recognized by Riverside Methodist Hospital's Library Resource Center. The library will be named in Dr. Vincent's honor.

NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by Susan Porter

Claims shift

Primary-care physicians who fail to make an early diagnosis of a problem are increasingly finding themselves the subjects of malpractice suits. So says a special report in a recent issue of *Medical Economics* which points out that misdiagnosis is quickly outpacing surgical problems as a motivation for filing malpractice claims.

Among vulnerable targets:

- physicians who don't detect early signs of diseases such as cancer and thus fail to refer patients to specialists at early stages,
- OBG specialists who fail to detect birth-related defects,
- physicians not up-to-date on new forms of treatment,
- emergency room physicians.

The report also points out that the computer age has helped fuel malpractice claims by allowing plaintiffs' lawyers to do more research in less time.

Some hospitals — also subjects of malpractice suits — are taking a stronger role, asking doctors to be more responsible for their actions and even dictating the amount of malpractice insurance they should carry.

Physicians, themselves, today are more willing to testify as expert witnesses in malpractice cases, the report states.

Women visit doctors more



Women live an average of eight years longer than men, yet they have more illnesses, are hospitalized more often and visit their physicians more frequently, according to a report issued recently by the National Center for Health Statistics, U.S. Department of Health and Human Services. Even when specific conditions related to sex differences such as pregnancy or illness of the reproductive organs are excluded, females visit their doctors 19% more often than their male counterparts, says the study titled "Sex Differences in Health and Use of Medical Care."

Why do women live longer? One reason may be that men fail to take care of their health in the same manner as women, the report hypothesizes. When men finally do seek care, they tend to be more seriously ill and suffer from more life-threatening diseases.

Women also perceive more symptoms and are more likely to change their activities, as a result, the report states.

Another theory is that females are biologically advantaged from birth. Some research indicates that biological mechanisms associated with women's reproductive capacity may provide protection; however, women have a higher morbidity due to reproduction and gynecological disorders.

"Infallibility" causes anxiety

Physicians taught they can not make mistakes may suffer severe anxiety, leading to substance abuse, depression and later "burnout," according to a recent report in the *Journal of the American Medical Association (JAMA)*. This concept of infallibility, often emphasized in medical schools, not only gives medical students false expectations but also blocks constructive criticism among peers, the study says.

Because a patient's well-being or even life is at stake, doctors in training are told they should not make mistakes — at least not serious ones. This often leads to the unrealistic assumption that physicians are not as fallible as other human beings, the researchers report.

Subsequently, most physicians expect excessive criticism should they make mistakes, according to the study. "This fear of criticism may be greatly out of proportion to actual critical comments made by faculty or fellow trainees, perhaps because of the high expectations that the young physician has for himself."

Among solutions suggested by the authors are that medical school professors teach their students to be as empathic with each other as they are with their patients.

Report recommends principles for AMA insanity defense policy

A 37-page report issued recently by the American Medical Association Committee on Medicolegal Problems recommends that the AMA support four principles in its policy concerning the insanity defense in criminal trials.

The report, which covers both the history and evolution of the insanity defense, recently was placed before the AMA House of Delegates by the Board of Trustees to help it reach its policy decision.

The recommendations are:

• Narrowing of the defense of insanity in criminal trials. The conventional insanity defense would be replaced by statutes that permit acquitting a defendant who, because of mental disease or defeat, did not have the state of mind ("mens rea") required as an element of the offense charged.

• Once acquitted, the defendant (whose own defense has proved the mental disease or defect) would be committed for treatment under legal standards of civil commitment.

• Complete or conditional release from treatment would require agreement by both medical certification and judicial determination that releases would pose no substantial public risk. Conditional release could require continuing psychiatric treatment. Failure to comply with the conditions would result in recommitment.

• The mental condition of a defendant who is not acquitted under "mens rea" provisions could be considered in sentencing. Such a defendant could be ordered hospitalized for treatment (instead of being imprisioned) for at least as long as the maximum term prescribed by law for the offense for which the defendant was convicted. If treatment ended sooner, the remainder of the sentence could be served in jail.

Psychological causes often overlooked

After more than a dozen hours of tutoring by psychiatrists, 66 Harvard Medical School students practicing history-taking and patient interviewing failed to ask questions about a patient's lifestyle, work, family life or general psychological well-being, says a report in a recent issue of the *American Journal of Psychiatry*.

As a result, the report continued, medical students often overlook psychological causes of poor health because they are biased towards purely biological explanations of disease.

Hormone links stress with later depression

Researchers from both the National Institute of Mental Health (NIMH) and the National Institute of Health (NIH) have come up with some new biological clues which may explain why susceptible individuals who experience severe stresses early in life may suffer depression and other psychiatric disorders as adults.

Their work, which was discussed at a seminar on the "Molecular Basis of Stress," according to a recent NIH publication, revolves around experiments with the recently purified neurohormone "corticotropin releasing factor" (CRF).

The scientists are interested in explaining how the key brain hormone may become hyperreactive in affective disorders, precipitating a cascade of abnormal endocrine responses typically seen in depressed patients, the report says.

The researchers conducted a number of experiments using synthetic CRF on both depressed patients and control groups. According to the report, their findings suggest:

- Depression appears to be a problem of the hypothalamus and/or higher brain centers.
- Depression involves an excess of CRF secretion.
- Early and prolonged stresses might sensitize genetically vulnerable individuals to chronically oversecrete CRF and hyperreact to stress in later life.
- An oversecretion of CRF may also result in other psychiatric illnesses, such as obsessive-compulsive disorder and anorexia nervosa.

The researchers hope their work will, among other things, lead to a more effective use of antidepressant drugs for "breaking the chain" of dysfunctional stress responses, the report says.



Introduction

The Pits and the Pendulum

By Leslie E. Whitmire, MD

The chronically mentally ill are sleeping in the streets with only their "rights" as shelter. America's new insane asylums are a collection of bus stations, abandoned buildings, and alleys where the deinstitutionalized can savor their freedom, as a significant segment of the "street people." The least restrictive treatment setting appears to have defined itself in many cases as homelessness.

Statistics point to the high percentage of mental illness afflicting the evergrowing subculture in our society called "street people." Communities throughout this country are experiencing this phenomenon. The severe mental disorder of schizophrenia was found in 37% of shelter residents in a recent Philadelphia study and in 72% of the homeless admitted to Bellevue Hospital emergency room. A number of studies have determined that 50% to 70% of the homeless manifest some type of psychiatric disorder. Recently 55 inmates at the County Jail in Toledo, Ohio had a history of mental illness and/or were being administered medication for the treatment of psychiatric symptoms. When the only modes of treatment for this large number of people consist of imprisonment or social castigation, it would seem that the care of the chronically mentally ill, who are also poor, has come full circle since the days of Dorothea Dix.

Why is this happening? As the result of several factors, there developed over many years an

overload in the institutional branch of the health system. Zealous reform as well as less altruistic motives resulted in injudicious utilization of available facilities. Psychiatrists and the mental health system were asked, perhaps ordered, by society to do the impossible. This Herculean task was to isolate, treat and cure while sheltering not only the mentally ill but criminals and other impoverished souls with whom the rest of society had no way or wish to deal.

In addition it was demanded that this overwhelming responsibility be carried out cheaply! Not surprisingly, the system was abused and floundered. The pendulum swung and the command issued forth to empty the "pits" called asylums. What followed was a rush of sometimes well-intentioned legislative activity without adequate planning and community support. The result denied many patients fundamental living needs without fulfilling the mandate of more appropriate psychiatric care and treatment. This national tragedy was personalized in a failure to find housing for some chronic patients while residential buildings were being demolished on the State Hospital grounds.

It is ironic that we now must deal with increased human misery that is the product of good-faith efforts to lessen human misery. All those involved in this disgraceful abandonment — lawyers, legislators and health professionals — must share responsibility for the lack of forward thinking and learn quickly from the situation so it can be corrected. Perhaps that fundamental lesson is that benevolent intentions can be sabotaged by a serious lack of both planning and previous direct experience and by placing emotional principles ahead of reality issues. Regardless of attempted denial of the current crisis, even among some mental health professionals, severe, chronic and disabling mental disorders which need institutional attention can no longer be ignored.

It behooves each one of us to reconsider and reassess our knowledge and attitudes, so as to approach these people in our society who need help because of a mental disorder and impoverished circumstances. We cannot put a law enforcement officer in a position of diagnosing a mental illness, nor can a mental health professional cure a criminal. The resources of social service agencies must be developed and utilized for those people who are neither mentally ill nor criminal but who are situationally disadvantaged. A rational coordination of societal responsibility and resources must be achieved so that society's attitudinal pendulum reaches a rational midpoint in the treatment of mental illness. Our professional responsibility and our human compassion must coalesce. **OSMA**

It is ironic that we now must deal with increased human misery that is the product of good-faith efforts to lessen human misery. All those involved in this disgraceful abandonment must share responsibility for the lack of forward thinking and learn quickly from the situation so it can be corrected.

Leslie E. Whitmire, MD, practices psychiatry in Toledo, and serves as Chairman of the Ohio State Medical Association's Committee on Mental Health.

We wish to thank...

The Journal wishes to thank the members of the Ohio State Medical Association's Committee on Mental Health, which provided valuable input, as well as assistance in structuring this issue.
Members of the committee are:

Leslie E. Whitmire, MD
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Resident
Columbus

Robert O. Cunningham, MD
New Carlisle

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Deinstitutionalization. Is It Working in Ohio?

Where Have All The Patients Gone?

By Robert J. McDevitt, MD and
By Ruth Archer McDevitt, RN, BSN

Twenty years ago, under the leadership of President John F. Kennedy, deinstitutionalization of the chronically mentally ill was adopted as a community mental health philosophy. In a spirit of concern and hope for the improvement of the plight of the mentally ill, the pivotal concept of planning for their care in Ohio, as elsewhere in the nation, was to provide treatment and rehabilitative services in their home communities. The assumption that returning these patients to their own communities would somehow improve their ability to cope with and tolerate the pressure of every day living in a non-sheltered environment has proved subsequently to be more than a little naive. However, the state hospital population in Ohio fell from a high of 28,367 in 1955 to 4,709 by June of 1982.[1] Concomitant with the decrease in inpatients, there was an increase in local outpatient resources throughout the state as a result of legislation passed by the state legislature (HB 648) in 1968. Community Mental Health Boards were appointed and charged with the responsibility of planning and developing programs for these patients as they were discharged from the state hospitals to the local communities. The membership of the 648 boards, as they came to be known, was made up of mental health professionals and, most importantly, community and business leaders, thus ensuring the involvement as well as the interest of local communities in caring for their mentally ill citizens. The programs that evolved included outpatient treatment centers and foster home placements for patients without families able or willing to take them into their homes.

In 1981 Talbot observed that contrary to expectations, only 25% of previously hospitalized chronically mentally ill patients were being cared for in these community programs; an astounding 75% were lost to follow-up. It is estimated that 20% of this group of former inpatients make up the population of "street people" in some of the nation's large cities; others are found in city and county jails. The remainder are assumed to be living either in family homes, rest homes or foster homes.[2] Natural attrition through death of these former state hospital patients in the late '60s and early '70s accounts for an additional decrease in their numbers.

While the previously institutionalized chronic patients are dwindling in number, a new type of non-institutionalized patient has had an unanticipated impact on community treatment resources.[2] These patients, called young adult chronics by Pepper,[3] are 18 to 35

While the previously institutionalized chronic patients are dwindling in number, a new type of non-institutionalized patient has had an unanticipated impact on community treatment resources. These patients, called young adult chronics, are 18 to 35 years of age, and exhibit such clinical features as apathy, anergy, slovenliness and anhedonia.

years of age. Their clinical features include apathy, anergy, slovenliness and anhedonia. About 35% are drug and alcohol abusers. Pepper estimates that 70% are living with their families or family members and are only admitted to hospitals for brief periods. These young adult chronics have poor records of compliance with treatment. As observed by Liberman and Foy,[4] "they will accept rescue, but rarely accept treatment." Their symptoms are remarkably similar to those of the older group of chronic patients who had spent many years living in institutions. One might reasonably conclude that these symptoms are characteristic of chronic mental illness rather than institutionalization.

Since mental health statistics do not readily identify these young adult chronic patients, there is a conflict of opinion about where they are treated. American Psychiatric Association studies[5] indicate that about 20% of the admissions to private psychiatric facilities are such patients. Goldman claims that most are admitted to state hospitals with acute episodes of illness and are over-represented in the readmission group.[2] There is also recent evidence that a significant percentage of these patients are found in the current jail population, perhaps as much as 18%, based on the observation that of the 6 million persons who were jailed in the nation in 1982, 900,000 were estimated to be mentally ill.[6]

The most consistant finding is the presence of these patients in the family home; the impact on the average family is profound. These patients are seldom employed and recent evidence reported by Feitel[7] indicates that they are severely cognitively impaired. All these clinical features mean that families, most often the women in the family, are thrust into the role of caretaker of the impaired and overtly ill. These patients are often acutely aware that they have not achieved the usual adult goals of independence and self-sufficiency and are demoralized by this recognition, compounding the problems of an already difficult situation. Lamb[8] suggests that their problems become intensified when they are subjected to unrealistic expectations from their families and mental health professionals.

The burden of the young chronic patient has been shifted to the family, the community, and sometimes the penal institutions; there is ample evidence that none of these settings can cope with these chronically ill, poorly controlled individuals. A California study reports that there is a significant group of younger patients, below the age of 30, who cannot adjust in any setting; these young people need special programs.[9]

Since these patients rarely come to public attention unless there is some public display of the mental illness, they remain a relatively invisible group. Only occasionally does their behavior attract attention and then they are promptly either jailed or hospitalized in a private or public inpatient institution for a short period. It is difficult to measure the impact of this group on the health and welfare of their families and, as suggested by Theur, the burden of care has fallen disproportionately on the women in the families.[10]

The impact of deinstitutionalization and non-institutionalization has not been adequately measured despite a bewildering array of available statistics. It has been a great success on paper, perhaps because the patient population has disappeared as a clearly identified group. In reality, for the most part, the patients are alive but not well; they do not seem to have achieved an improved quality of life as expected two decades ago when this enlightened approach to treatment was first proposed. These patients still have untreated and unresolved mental problems which have not been cured or improved by returning them to their families. The financial burden of their care has not decreased; it has merely been redistributed. The statistics of the Ohio State Department of Mental Health barely hint at the burden that families bear in the care of their chronically ill offspring. Recently, alliances of the relatives of these patients have been organized and have become an important group in demanding care and help for their family members.

Paul McAvoy, DSW, Acting Director of the Department of Mental Health,[11] in a recent address to the Psychiatric Section of the American Hospital Association, spoke of a plan

continued on next page

Deinstitutionalization. Is it Working?

continued

for the state to reduce its role and responsibilities as a provider of direct services. McAvoy reported that the state legislature had mandated that the Department of Mental Health explore the possibility that community hospitals assume responsibility for providing acute care services. This plan has not been developed fully, but has considerable promise since Ohio has 64 psychiatric units in community hospitals, well distributed geographically.

McAvoy also saw an "uncertain future" in the Department of Mental Health's responsibility for the extended care patients, except for some few patients in forensic centers. This presumes the development of adequate community resources. Although McAvoy notes there has been a 17.5% increase in the chronic residual population in long term state facilities in 1982, he also says, "I say this with the knowledge that community programs in Ohio do not have existing programs in sufficient numbers to address the needs of these patients." Although it is hoped that these individuals will benefit from extensive rehabilitation, the issues of basic knowledge of the causes of such extensive illness is not addressed.

In face of this statistic, and recognizing the reality of a residual group of chronic patients whose illness does not respond to acute, biological, social, and psychological intervention, the Department of Mental Health nevertheless maintains "at this point it is questionable if a hard core, extended care patient exists." But, the physicians in Ohio know that these individuals do exist, on our streets, in our jails, and in their family homes. What does not yet exist is a sophisticated clinical care system to insure adequate treatment of these young adult chronic patients. This kind of effort may not only require a redistribution of funds, but increased funding for research into the causes of chronic mental illness and for realistic plans for the management of its victims with assistance to their families as an integral aspect of such plans. In this area lies any real hope of alleviating this problem over the long term. **OSMA**

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Robert J. McDevitt, MD, practices psychiatry in Cincinnati, Ohio and serves as a member of the OSMA Committee on Mental Health. Ruth Archer McDevitt, RN, works in the Department of Nuclear Medicine, University of Cincinnati.

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DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta-blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions; psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

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Deinstitutionalization. Is It Working in Ohio?

THE STATE'S VIEW

By John Davis, MD

Deinstitutionalization — since its inception some 20 years ago — has been widely criticized for throwing hundreds of thousands of unprepared, defenseless individuals out into an unsupportive, unprepared, unwelcoming world. This massive endeavor, which held such promise of better lives for the chronically mentally ill, has, in recent years, lost much of its support because it has failed to adequately provide for the needs of this population now existing in our communities.

Genuinely concerned individuals and groups (and some not so genuinely concerned) are now proposing that public mental hospitals once again be expanded by means of the adoption of less rigorous admissions policies and liberalized continuing stay criteria. Many physicians have become convinced of the lack of efficacy of deinstitutionalization, and accuse its supporters of inhuman disregard for those who now find themselves in shocking impoverishment, without support or any semblance of therapy. I welcome this opportunity to describe the position of the Department of Mental Health and to briefly discuss some aspects of its policy initiatives.

Misperception and misinformation about the chronically mentally ill are rife among the laity and professions. The popular belief that this population is more dangerous than others is unfounded. The notorious crimes of the psychotic, given intense press coverage, along with the mythology of the terrifying danger of the psychotic in fictional entertainment media have fomented this perception. It is not supportable, however, that a greater proportion of mentally ill residing in the community is more dangerous than other distinct groups.

Recent debate over the Not Guilty by Reason of Insanity (NGRI) plea has, regrettably, resulted in discord among medical and mental health professionals. Of even greater concern are the interpretations of the public resulting from this very public dispute that all mentally ill persons are potentially dangerous, calculating and malevolent and that, for this reason, must be locked away. It seems of less importance to the average person that the incarcerating facility is a prison or a mental hospital because the difference between criminals and the mentally ill has become blurred.

The rise in public awareness of "street people" has contributed to the belief that this is the direct result of deinstitutionalization. This is simply not the case.

In addition, the rise in public awareness of "street people" has contributed to the belief that this is the direct result of deinstitutionalization policies. This is simply not the case. The perceived rapid increase of these individuals in our cities is a recent phenomenon, compared to the many years of releasing the chronically mentally ill into the communities. If there had been a cause-effect relationship, the increased presence of "street people" would have followed more closely the most rapid period of deinstitutionalization which occurred several years ago.

It is certainly true that mentally ill individuals are in the ranks of "street people" (sometimes flamboyantly so). However, in large measure, this group is composed of the unemployed, the dependent dispossessed, peregrinators, others "down on their luck," and victims of unsuccessful, current and previous social policies.

Regardless of the composition of the group or the reason for its being there, the increased visibility of the people who make up this group has been met by public dismay. It is entirely understandable (although it is as immoral as many understandable things may be) that a common response might be to provide them treatment — in a state mental hospital.

However, institutionalization of this sort is a call to incarceration for unsubstantiated cause. It dangerously

approximates the shameful, tyrannical admissions and commitment policies of a more naive time, from which the image of state mental hospitals has yet to recover. I hope that this era of oppression is relegated to our past. It would be unconscionable to implement it today in light of current psychiatric knowledge, as well as increased regard for the sensitivity to the rights of all people.

What do we propose to do for those mentally ill individuals already in the community who are suffering from alarming neglect? The Department of Mental Health is vitally concerned about the paucity of a variety of services to these people. There is no argument that deinstitutionalization has failed. While the quality of life improved for some people, the tragic neglect of the chronically mentally ill in our communities cannot be ignored. The solution to this pressing situation will not be simple and it will not be immediate.

The Department of Mental Health subscribes to the widely held belief that large institutions (no matter how "humane") which provide long-term sanctuary are, to put it bluntly, simply not good for people. Many low-functioning, chronically ill individuals (those who exhibit little ability to independently perform basic skills, to engage in social discourse, to participate in and enjoy activities, to work) may have regressed to this state not in consequence of the natural course of chronic psychosis. The concept that they are victims of the limitations and constraints imposed by the institutions themselves is hardly a new one. And, although there are now those who would take issue with this, most mental health professionals acknowledge this every time they refer to a patient as being "institutionalized." It would be reasonable to assume that regression is due not only to the disease process, nor only to the institutions impact on the individual; but is rather the result of an interaction of the one with the other in a regressive symbiosis.

Unfortunately, despite advances in psychiatry and allied mental health professions, chronic mental illness remains one of the most resistive and devastating of human disorders. Thus the "natural progression" of the chronically ill patient has been difficult to arrest by conventional forms of psychotherapy and/or the use of psychotropic medications.

The one factor which we do have some control over is the confinement of these people in large state repositories. The contention that state hospitals needn't be warehouses is only appropriate from those of our peers who have assertively tried to advocate for the system.

The Department of Mental Health subscribes to the widely held belief that large institutions which provide long-term sanctuary are, to put it bluntly, simply not good for people.

Funding for mental health in this state has always been inadequate to provide the professional staffs and programs needed to treat this large population. This system (and, in consequence, its underserved patients) has had many advocates who have contributed exhaustively of their time and expertise; however there is a troubling history of disinterest from private and hospital-based psychiatrists. This absence of involvement by some of the most highly respected clinicians in this state is a fair measure of the degree of concern which they hold for the mentally ill individual whose only option has been the state mental hospital. Truly adequate (not to say excellent) inpatient therapy comes only at a high premium, and many who might have provided the system with support have been silent.

The Department of Mental Health has taken a strong position that it would be a quick-fix tactic to expand the state hospital facilities and proceed with business as usual. It would not only undo the deinstitutionalization process (admittedly inadequate as it has been) but it would also be fundamentally inconsistent (as government agencies have a propensity to be), and the result would be the return of many of our people to the constant, coercive influence of the institution. When one considers the current economic climate, the expenditure to the state would be enormous just to provide the limited repertoire of treatment which was provided years ago. It would not address the problem of institutionalization already discussed.

While the expansion of state hospital facilities would respond to the issue of the neglected mentally ill in the community, this process would not be immediate. Because of its lack of complexity (you have a hospital; you have a needy group of patients in the community; you put the patients into the hospital), charting this course might be more readily accepted by many who are concerned over the problem. It would be in some ways less controversial than the policies now in development and early implementation. It would represent to the mentally ill of this state the forfeit of hope.

During the earlier years of deinstitutionalization, there were few community alternatives for the support of newly released patients. At that time, the advent of effective antipsychotics was seen as a panacea; the ongoing needs of these people were little recognized.

The development of the community mental health center movement was a federal initiative to provide a range of therapies to the poor who had little access to mental health resources. These centers have, indeed, made mental health services more accessible to all people and have made a distinctive impact on our society.

Since most of those released from

state institutions have limited financial resources, it has fallen on the mental health centers to provide services for them. Due to a variety of influences (inadequate community support; absence of a unified, systems approach permitting the centers' input into statewide programmatic design; lack of effective communication; withdrawal of federal subsidies and grants), it has not been possible for mental health centers to adequately meet the wide range of needs of this deinstitutionalized population.

Other human service groups and agencies have been established over the years. Many are recognized as effective, legitimate organizations which have made distinctive contributions to the well-being of this population. The essential points are that: a) the state mental hospital system was a distinct arm of the Department of Mental Health; program development tended to be autonomous, having little continuity with the programs of community agencies and groups; b) there have never been enough community-based resources, facilities and programs to provide satisfactory support and treatment for this population; c) state level guidance to communities to identify a variety of funding resources for local programs was not given due priority; and d) an efficient network of all community services and resources designed to integrate and coordinate the support, care and treatment to individual needs never got off the ground.

The Department of Mental Health is currently addressing these problems with the goal of implementing a statewide network of participant groups and organizations. These would collaborate with the Department to provide effective, accessible support, including adequate housing, treatment, prevocational and vocational training, rehabilitation and individual case management.

It becomes obvious that this is an enormous effort which requires the enthusiastic participation of the organizations involved, as well as extensive "up-front" planning. Implementation will be gradual, requiring accurately choreographed movement of manpower, information, financial resources, identified responsibilities, etc.

The Department intends to turn over the responsibility of acute care to non-state, community-based hospitals, with funding provided through the 648 Boards. A contract with one hospital, which is to provide admissions and acute care, has been implemented and serves as a pilot model. This endeavor has allowed for problem identification and adequate lead time to rectify problems before extending the effort to other communities.

As this vast network begins to function, it is expected that many of the chronically mentally ill who remain in our state hospitals may be moved back into their communities with little disruption of support.

As this vast network begins to function and appropriate community resources are expanded, it is expected that many of the chronically mentally ill who remain in our state hospitals may be moved back into their communities with little disruption of support. It is a goal of the Department to drastically reduce the number of state hospitals, although it may not be possible to effectively and humanely transfer the most disturbed or regressed to alternative community settings. Therefore, the forensic hospitals will continue to be operated by the Department.

This reduction in the Department's direct care responsibilities will permit it to assume an assertive role in mental health issues. There will be expanding involvement in coordination activities, proposal of system-wide initiatives, monitoring, funding, licensure and standards, education, research, prevention initiatives and support services. Patients and former patients will be given expanded input as consumers of services.

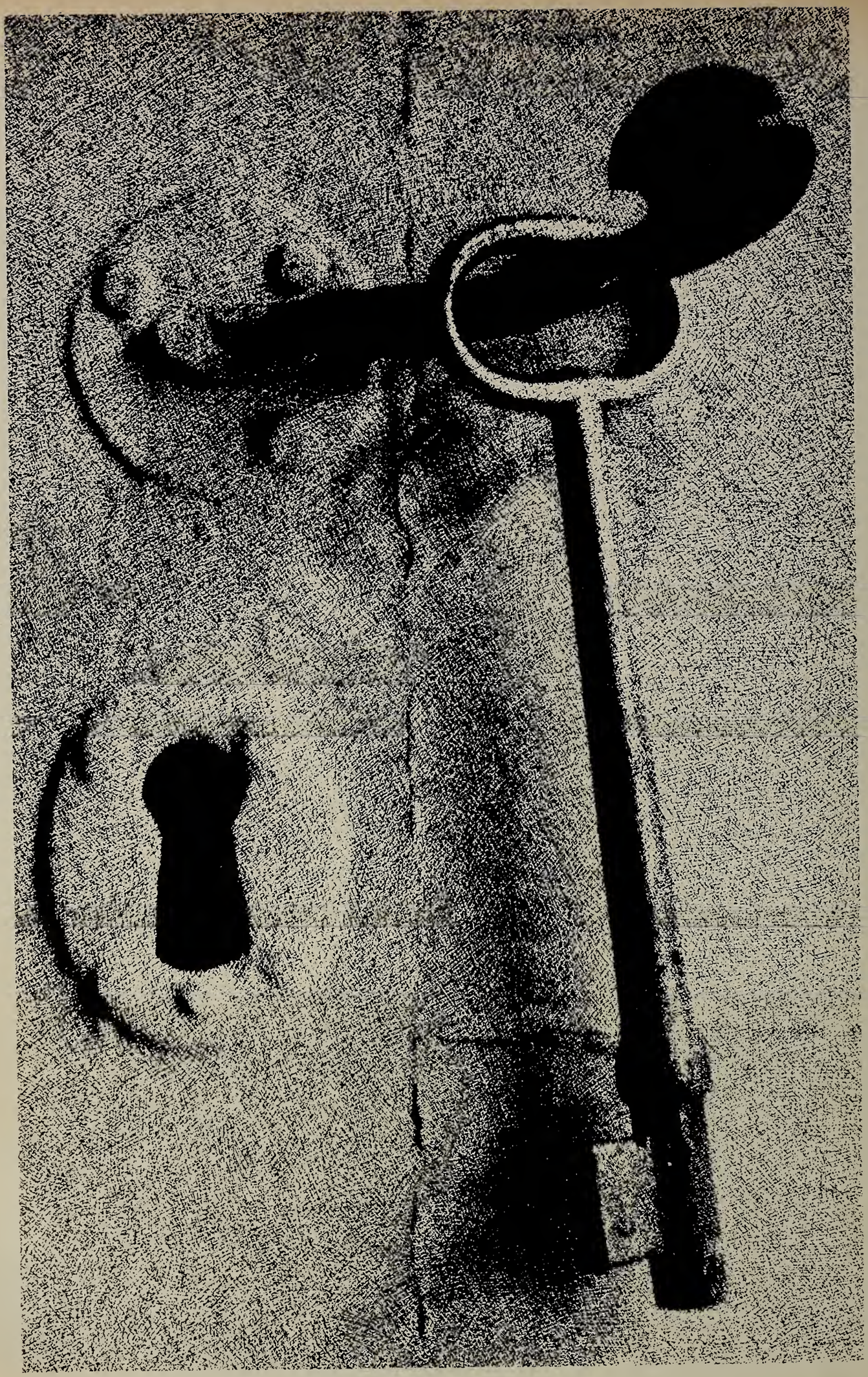
This last policy has, in fact, been implemented, with the participation of current consumers of mental health services on several of the task forces impacting on the future policies and directives of the Department. These people have already made an impact by taking issue with some of our percepts and assumptions.

While some physicians have expressed alarm over the belief that the state is encroaching into areas traditionally the domain of psychiatrists, there are others (myself included) who welcome more collaboration with other mental health professionals. It is undoubtedly true that much of the authority which, in the past, has been taken for granted will give way to collaboration with other professionals and patients themselves. However, all of the medical authority of the psychiatrist should and will be preserved. Rather than dreading the change of departmental mission and its effects, I am excited about the prospects as they impact upon our department, psychiatric practice and our people.

John Davis, MD, is Medical Director, Central Ohio Psychiatric Hospital, Columbus.

Otolaryngologists schedule CME for March

CONTEMPORARY CONCEPTS IN OTOLARYNGOLOGY: March 31-April 7, 1984; Caneel Bay Resort, St. John, U.S. Virgin Islands; sponsor: University of Cincinnati Medical Center; cosponsor: The Communicative Disorders Foundation; 30 credit hours; contact: Ms. Robbie Cornelison, Program Coordinator, Dept. of Otolaryngology and Maxillofacial Surgery; University of Cincinnati Medical Center; M.L. #528, Cincinnati, OH 45267.



Mental Health Behind Bars

Mental Health in an Ohio Jail Community

By Melvyn M. Nizny, MD

ABSTRACT

In 1978, psychiatric evaluation of 50 volunteer inmates conducted at the Hamilton County (Ohio) Jail revealed one-half had had psychiatric treatment prior to incarceration. Eighty-four percent of the sample equaling 14% of the average daily jail census was diagnosed as having significant psychiatric disorders. One out of seven required psychiatric hospitalization for acute disorders.

Data from this survey points out the urgent need for mental health services.

PURPOSE

As part of a legal action,* I was asked to serve as psychiatric consultant in order to assess (1) the mental state of the inmates and (2) the psychological effects of incarceration upon them.

I decided to sample, by means of structured psychiatric interviews, 50 inmates who volunteered to participate in the project.

I wanted to determine (1) what number of mentally ill people were in jail, (2) what kinds and types of mental health problems existed in this sample population, (3) what the inmates described and listed as stresses upon their mental health, (4) what facilities and personnel were available for assistance.

There was no attempt to include or exclude any individual in this study.

At present, because of the absence of any in-house social work staff, there is no formal or orderly channel for referral and/or evaluation of inmates with emotional, behavioral, family, or other personal problems.

THE SURVEY

The questionnaire was distilled from and patterned after a psychiatric clinical examination that the author had used in other forensic psychiatric settings. It was used to note the presence or absence of whatever degree of psychological abnormality that might exist, given the time allotted for each exam. I then attempted to establish if there was any link between the inmates' mental state and their incarceration. I further sought to define those inmates who might benefit from psychiatric help, in contrast to those who might not benefit.

The questionnaire was designed to elicit information that would aid in establishing a diagnosis which would run the full range specified in the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.*

SURVEY RESULTS

1. AGE

The survey encompassed 50 people; 37 men and 13 women. Age range was 19 to 63.

*This report was prepared for the Legal Aid Society of Hamilton County, with funds provided by the NAACP Legal Defense Fund.

Table 1

Age	
18 to 19 years	7
20 to 29 years	27
30 to 39 years	9
40 to 49 years	4
50 years and over	1

Beyond age 36 there were five participants, ages 43 (2), 44 (1), 47 (1) and 63 (1). Thus, outside the major age group of 19 to 40, it would behoove an examiner to be alerted to a possible major degree in deviant behavior in those far removed from the age norm, here, 10% of those studied.

2. EDUCATIONAL LEVEL

Educational level, here used roughly as one indicator of intellectual level, is indicated below.

Table 2

Educational Level	
Grade school	7
Partial high school	17
High school graduate	20
College or vocational	6

Here again, those deserving special inquiry would be anyone outside of the usual amount of education, here grades 9 through 12, which represents 37 inmates or 74%; the other 26 were divided almost equally between grade school level and college level.

3. MENTAL HEALTH CONTACT

Thirty-three individuals, 66% of the total, had had contact with psychiatrists, psychologists or social workers. This included 13 for hospitalization, 11 for outpatient treatment and nine for evaluation. No inmate was counted twice.

Table 3

No psychiatric contact	17
Evaluation only	9
Psychiatric outpatient care	11
Psychiatric hospitalization	13

Excluding those seen for evaluation, the remaining 24 represented 48% of this survey and 8% of the jail daily census of 300.

These inmates with prior psychiatric treatment and/or hospitalization would be prime candidates for possible decompensation under the stress imposed by being in the jail setting. This is not to say that they will experience more than expected difficulties, only that an intake or medical staff could be alerted to that possibility within this group at risk.

4. SUBSTANCE USE AND ABUSE

Of the 50 inmates, 15 inmates gave history of prescription for psychotrophic medications out of jail, while only one inmate was seen who was on such medication in jail.

Inmates were asked if the use or "abuse" was a problem to them. This was felt, from the author's clinical experience, to denote (1) a degree of insight into their situation and (2) how much pain, so to speak, they were experiencing with regard to the substance abuse or the reason for the excessive use. The above was followed with a question as to whether or not the inmate had sought treatment in the past or had interest in treatment in the future. Again, these were likewise felt to be indicators, of insight, of pain as well as motivation for change.

The fact that the examiner establishes a psychiatric diagnosis of, say addiction or personality disorder, does not automatically call for a treatment program.

There were 26 individuals with drug and/or alcohol abuse problems. Fifteen were drug abuse alone, six were alcohol abuse alone and the remaining five were combined drug and alcohol abuse. These 26 equaled 52% of the total sample or about 9% of the average daily jail census.

Table 4

Alcohol Abuse Alone	6
Drug Abuse Alone	15
Drug and Alcohol Abuse	5
Combined Total	26 or 52%
Total Alcohol Abuse	11 or 22%
Total Drug Abuse	20 or 40%

First, **Alcohol:** 16 inmates noted use of alcohol, 14 minimally or moderately, but they did not consider their usage to be a problem, nor was it deemed to be one by the examiner.

An additional 11 inmates gave history of excessive alcohol use, 24% of the total survey.

Second, **Drugs:** Prescription and nonprescription drug use is the other major group of substances used or abused. Twenty-seven of the 50 inmates, or 54%, admitted to using a variety of drugs. Twenty, or 40%, of the entire sample were classified as excessive users or abusers; 13 inmates felt that their abuse was a problem, yet only 10 of the 13 were felt to be appropriate for a trial with a drug treatment-rehabilitation program; still this is 20% of the entire sample.

It is also important to be able to identify possible coexisting underlying disease or dysfunctions, such as mental retardation, psychosis and organic brain disorder. One or all of these can be present in addition to drug abuse and thus predispose an individual to lack of control. Unless the underlying problem is identified and assisted, the cycle of drug abuse would be perpetuated.

The question about drug withdrawal needs to be attended to in any jail given the high frequency of sudden death from alcohol or drug withdrawal especially from seizures, dehydration and hyperpyrexia. Medical procedures need to be worked out ahead of time so as to routinely identify and thus treat these preventable disorders.

Not all, despite the excessive, lengthy, or multiple drug use, identify that a problem exists or wish help. The fact that the examiner establishes a psychiatric diagnosis of, say addiction or personality disorder, does not automatically call for a treatment program. Recognition that many persons are more appropriately dealt with administratively rather than medically is a necessary distinction, but there must be an orderly

procedure for this type of process.

5. PERSONAL FACTORS

Here, items having to do with sexual or aggressive impulses as well as self-esteem were investigated. Four persons complained of some type of sexually-related difficulty in jail but none gave a history of sexually-related disease in jail. Five others cited such problems out of jail while 19 noted disease, out of jail.

Aggressive impulses pose serious and ubiquitous problems. To begin with, 19 inmates gave a clear history of violence while growing up, such as physical fights or beatings within their nuclear families. This is known to predispose one to learning inadequate impulse control toward others and oneself, i.e. it should be borne in mind in thinking about suicidal as well as homicidal impulses. Twenty-seven inmates, 52% of the survey, gave a history of fighting; 11 with use of weapons, 16 without weapons. Two persons described fighting; 11 with use of weapons, 16 without weapons. Two persons described fighting in jail. Coupled with the above, 12 inmates described their tempers as, in some degree, volatile.

Table 5

Aggressive Behavior	
History of Fighting	27
With Weapons	11
Without Weapons	16
Volatile Temper	12
Fighting In Jail	2

Specific cases, presented to the examiner illustrate the "razor's edge" of volatility and potential for aggressive behavior that exists in the jail. Add to confinement a tendency toward anti-social behavior, then limit opportunity for sublimation and appropriate expression of anger by limiting recreational activity; the result is a clear potential for violence. The rioting which erupts periodically in jail settings throughout this country is but the sudden release of long smoldering resentment. If, in addition, inmates with paranoid psychotic features are present without medication, then one enhances the possibility of fighting which may be the result of the persecutory person's attempted self defense, i.e. they may strike out in response to a paranoid delusion.

Control of violence must begin at the jail door where those with mental disorders or history of aggressive behavior are identified, monitored and/or treated. Inmates, as individuals, presumably have a right to a safe environment free from the assaultiveness of others.

6. MENTAL STATUS

One issue examined in this section concerned trust in others. A subjective clinical judgment was made on a continuum: from those who were open with many personal contacts, to those who'd keep to themselves or were frankly paranoid. Seventeen inmates were listed with acceptable levels of trust, 22 had some marked limitation in relating to others with 12 who were found to be markedly suspicious either by their own statements or by the examiner's observation of paranoid thinking to one degree or another.

Control of violence must begin at the jail door where those with mental disorders or history of aggressive behavior are identified, monitored and/or treated.

When people learn to hate, be mistrustful, avoid others or be suspicious, it is with cause. Some event(s) and interactions have led them to be the way they are. Understanding that background with the inmate helps to develop a bond, some degree of rapport between interviewer and interviewee. It is a must for doctor/patient, attorney/client and anyone who might be involved in rehabilitative efforts. It is just as important for the correctional officer in his or her contact — day to day — with the inmate, because by knowing and adequately gauging an inmate's level of trust, an officer can act either to inflame or pacify those in his or her charge. As an extension, those persons, be they guards or others, who are themselves mistrustful, harsh or cruel need to be removed from the inmate's contact, because they are as dangerous as an inmate who is out of control — that is, by continuing to stir dissention. The inmate population is by its very nature helpless and therefore prone to over-react to any slight or criticism. The old adage — "How does one get 'wild' rice? By taking 'tame' rice and irritating it," — should be born in mind.

The jail population was surveyed by another parameter: an earliest memory, which in a clinical examination provides clues and impressions about the overall personality, one's concerns, conflicts and adaptation to life. Thirty-four of the 50 inmates, 68%, described memories of a traumatic nature, which demonstrates a substrata, representing a strong undercurrent of stress within the individual personality. These cases include situations of physical and emotional injury or trauma, death of significant figures to the, then, child and/or lack of adequate parenting.

The inquiry about inmate's self-assessment was pursued along another line — that of self-esteem. Most inmates were satisfied with themselves — 41 of 50, or 82% — with only six undecided and the remaining three with an unambivalent dislike for themselves. Yet even within those sub-groups, there existed 32 of 50, 64%, who had some interest in changing something about themselves, even though they were basically satisfied. Eighteen inmates, 36%, felt that they were fine the way they were. A level of self-awareness and introspective ability, and shame or guilt about their personal difficulties, all contribute to an understanding of possible motivation for change. Thus, rehabilitative efforts have their basis in defining some starting point: Is there something that the inmate wants

continued on next page

The inmate population is by its very nature helpless and therefore prone to over-react to any slight or criticism. The old adage — How does one get 'wild' rice? By taking 'tame' rice and irritating it — should be born in mind.

to change, or is it only a reaction to authority which dictates that limits will be set or that some behavior will change "or else"?

Another consideration would be how realistic or unrealistic is the expression or wish to change — is it superficial, designed to influence others or deep-felt?

Table 6

	Number	%
Significant Anxiety	29	58%
Significant Depression	30	60%
Crying Spells in Jail	16	32%
Suicidal Ideation	4	8%
Homicidal Ideation	2	4%
Significant Insomnia	39	78%
Nightmares	20	40%

The constellations of anxiety and depression either alone or expressed by some other specific symptom were present as follows. Twenty-nine of 50 (58%) of the inmates answered "yes" to questions about anxiety or nervousness or their equivalent, in jail. These included restlessness, pacing, shaking, insomnia, excessive smoking or coffee intake, tension headaches, quickness of temper and fighting, nail biting, withdrawal from others, "stomach ulcers with pain," fright, confusion, skin eruption and hives.

Thirty of 50 (60%) complained of depression in jail along a continuum which included mood disruption, irritability, helplessness, hopelessness, crying spells, insomnia, withdrawal including silence, suicidal or homicidal ideation, hallucinations, and preoccupation with death.

Of the depressive symptoms, 16 inmates (32%) reported crying spells in jail, four (8%) described current suicidal ideation and two had ongoing homicidal thinking, i.e. there is someone out of jail that they want to kill. Eleven inmates (22%) are experiencing a preoccupation with death, usually as part of an ongoing depression.

Fourteen inmates (28%) were found to be experiencing two or more items out of five which included crying spells, preoccupation with death, nightmares, suicidal or homicidal thinking. These people are clinically, severely depressed. Other specialized problems were noted and had gone untreated.

Thirty-nine of 50 or 78% of inmates were found to be experiencing a significant degree of sleep disruption or insomnia. Their discomfort was not related to the physical conditions of, say, their beds, but rather to personalized conflicts. Twenty, or 40% of the inmates vividly describe traumatic or violent nightmares as part of their sleep disruption; these were often of a recurring nature, signifying an ongoing, intense, disruptive neurotic (or psychotic) conflict. Seven of these involved images of physical harm, 17 of terrifying emotional distress and four included experiences of death.

Here again, as with the history taking of early memory, investigation of insomnia and the dreams and nightmares that keep the inmates awake offer an opportunity to pinpoint areas of stress and distress. In addition, they contribute to the understanding of the depth and breadth of emotional problems. Here also is a take-off point for helping the patient to gain relief via discussion or short-term psychotherapy of their focal conflicts.

Diagnostically, using the *American Psychiatric Association's DSM-II* referred to previously, individuals were noted to fit the following categories in Table 7.

Table 7 enumerates the existence of a plethora of psychiatrically-diagnosable disorders. Because, in many cases, there was more than one serious illness process, they were listed separately as "primary" and "secondary" diagnoses but with the emphasis on co-existent disease, one influencing and exacerbating the other. The personality diagnosis of "antisocial personality" was not defined, except as a primary diagnosis; in some degree, also, one might expect antisocial factors to be part and parcel of a felony experience, so that diagnosing it adds little to our understanding of the illness pattern.

Table 7

		Co-existant Primary	Diagnoses Secondary
I	Mental Retardation	0	2
II	Organic Brain Syndrome	2	3
III	Psychosis not attributable to physical condition, including Schizophrenia, Borderline State, Manic-Depressive Illness, Psychotic Depression	13	0
IV	Neurosis (mainly depression)	8	2
V	Personality Disorder		
	Alcoholism	6	0
	Drug Dependence	8	7
	Drug and Alcohol	3	2
	Other Personality Disorder*	4	0
VI	Psychophysiologic Disorder	2	2
VII	No Diagnosis	4	0
		50	18
	Total	68	

*only made as primary diagnosis

Forty-two of 50 inmates, or 84% of this survey, warranted a primary diagnosis, excluding personality disorder but including addictions.

Eighteen of 50 inmates warranted a secondary diagnosis.

Twenty-six of 50 inmates, or 52%, had a significant problem with drug or alcohol addiction.

These 42 inmates represented 14% of the average daily jail census of 300 inmates.

Of those with diagnosed conditions, seven individuals or 14% were found by the author to be sufficiently decompensated to warrant psychiatric hospitalization at the time of the study.

Of the inmates given diagnoses, 32 inmates, or 64% of the study, were found to be sufficiently distressed or disrupted, to be in need of psychiatric intervention and to be motivated for such assistance.

CONCLUSIONS

(1) This survey, undertaken at the request of the Legal Aid Society, consisted of psychiatric examination of 50 volunteer inmates at the Hamilton County (Ohio) Jail in 1978.

(2) Forty-eight percent of the sample, equaling 8% of the average daily jail census, had had psychiatric treatment prior to incarceration and therefore would be prime candidates for possible decompensation given the stress of incarceration (i.e. that they would be expected to be at greater risk than the population at large).

(3) Eighty-four percent of the sample, equaling 14% of the average daily jail census, had emotional problems sufficient to warrant a psychiatric diagnosis.

Of these, one-in-seven were decompensated to the point of requiring psychiatric hospitalization.

Most of the impaired group, or 64%, were in need of and expressed an interest in psychiatric treatment. These were primarily for drug or alcohol addiction, as well as for disorders of psychotic proportion.

(4) The lack of adequate evaluation and treatment of inmates is detrimental to their own health and safety and the health and safety of those incarcerated with them. To this end, a mental health team should be involved in the screening of inmates upon entry to jail, in order to identify those in need of medical-psychiatric help to include those whose personal disruption may constitute a danger to themselves or others.

Correctional officers need to be educated in order to help them to be aware of individuals whose distress or behavior is a signal or sign of some intense personal disruption. Both of these recommendations would be in keeping with the American Medical Association's Standards for the Accreditation of Medical Care and Health Services in Jails.

(5) Some beginning inroads might be made in the "revolving door" or recidivism by identifying those individuals who might warrant trial of some treatment intervention, as opposed to those who would be expected to respond only to administrative limit setting.

Melvyn M. Nizny, MD, practices psychiatry in Cincinnati. He has served as Consultant and Supervisor to the Court Psychiatric Center, Cincinnati Correctional Institute, and serves as Examiner for the American Board of Psychiatry and Neurology.

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"Our cells are beginning to look like the back wards at the Central Ohio Psychiatric Hospital. Everything is the same, they've just changed the address is all. It's the same locked environment, the same oppressive conditions . . ."

—Barbara Malone
Deputy,
Franklin County Jail

Mental Health Behind Bars

How Deinstitutionalization Is Affecting Ohio's Prisons and Jails

By Karen S. Edwards

In November last year, the *American Medical News* ran a story, "Prisons Viewed as the 'New Mental Hospitals'."

The article quoted jail psychologist Lawrence Cohen from Mount Holly, New Jersey as saying, "It is true that the population of mental health patients and jails are beginning to merge. Because of often irresponsible deinstitutionalization, which lacks follow-up of patients once they are discharged from state psychiatric hospitals, jails are becoming the new mental hospitals."

It's a grim accusation — and perhaps there is some grim irony in the fact that, here in Ohio, one of the state's oldest mental hospitals is being turned into a low-security prison, and/or prison guard training ground.

But whether or not deinstitutionalization is having any effect on Ohio's prison and jail population depends, to a large extent, on whom you ask.

"I don't have any statistics, but I don't think deinstitutionalization is affecting us much at the prison level," says Paul Goggin, Assistant Director at the Ohio Department of Correction and Rehabilitation.

"Yes, we're seeing more mentally retarded prisoners, but we are seeing more prisoners in general, so it stands to reason that this segment of the prison population would expand," Goggin adds.

The state currently incarcerates approximately 18,000 prisoners in its 11 facilities, but the Department's Director of Psychological Services, William Gilbert, PhD, agrees that deinstitutionalization has had little effect on the prison population to date.

"If the deinstitutionalized are committing crimes, it has not yet come to the point of serious crime," says Gilbert, "so we are not seeing many deinstitutionalized people in the state prisons."

He adds, however, that there is a higher rate of prisoners who are chronically mentally ill, and a higher number of these are still in treatment.

"Deinstitutionalization does not really apply when you speak in terms of Lima State Hospital," says Gilbert. Lima is the facility where most of the male inmates in need of psychiatric care are sent. The women are usually sent to a facility in Columbus.

"If a prisoner is probated to Lima for care, he is not released into the community, he is sent back to us."

And so the cycle begins. The prisoner may require additional treatment and be returned to Lima, then sent back to the prison when that treatment is complete.

"Although there is a high number of prisoners in need of psychiatric care, it would be difficult to say that we're seeing any more. We're basically seeing the same prisoners over and over again."

The problem begins when a prisoner with a psychiatric history is released.

"Since deinstitutionalization, the need for after care services has increased, but because of funding difficulties, services have not been able to keep up with demand. Those who were receiving institutionalized care now have to depend on the community mental health services for their counseling — and there are simply not enough services to handle everyone as adequately as might be hoped for."

Gilbert will also readily admit that the effect of deinstitutionalization is more apt to be felt at the jail level where those incarcerated for lesser crimes are held — a theory that Barbara Malone, a classification deputy at the Franklin County Jail, is quick to substantiate.

Malone is an intense, vocal, outgoing young woman in her early thirties. She's quick to admit that she's not degreed, but her years of experience in mental health services, both in Minnesota and in Columbus at

Deinstitutionalization. How It's Affecting Ohio Prisons and Jails

continued

the Community Mental Health Center, have caused her to be the principal trouble-shooter — the one to turn to when prisoners with "behavior" problems come into the jail.

"I was concerned about the mental health problems I was seeing in the inmates, and, on my own, I began to gather some statistics on the problem," Malone says. "It was soon obvious from even rough statistics that after care services were flunking in the community, and that we were incarcerating more and more prisoners who had some mental health problems."

She says that of the approximately 260 inmates who come into the jail each month, as many as 150 of these may exhibit some type of mental problem.

"Our jail holds 650 prisoners, and I'd say that, on a monthly basis, we average between 120-135 prisoners who need counseling."

Local community mental health service employees are regular visitors to the jail, some seeing between seven and nine clients once a week; others having to return to the facility at least twice a week to accommodate all those who need their services.

Malone doesn't hesitate to blame deinstitutionalization for the increased numbers.

"We've noticed, especially, an increase in the number of mentally retarded in the last three years, when deinstitutionalization really began in earnest," she says.

"We get maybe eight a month, and they are far worse for us to deal with than the mentally ill, because they have to be protected from the other inmates."

Currently, the jail has only 24 cells in what it calls its "protective range."

"So that means that most of them are placed in with the general population."

And Malone fears those numbers will increase.

"On paper, deinstitutionalization is a very ideal arrangement, but it just doesn't work. Everyone can't make it in the community, and the problem with the mentally retarded is that you can't really rehabilitate these people.

"The types of crimes they commit are usually petty in nature, but they are generally so socially outrageous, that the community won't put up with them."

She cites an example of a prisoner who came into the jail so retarded "we had to teach him how to use a spoon.

"When he was released, he went to a dirty book store and ordered the owner to show him all the dirty books. He just wanted to look at the pictures, but because he had a water gun in his pocket, he was charged with robbery."

Downtown businesses, she says, are tired of having to deal with all the vagrants who wander into their stores, loitering and creating disturbances.

Jails have become caretakers for a population that has long been ignored, and are still being ignored. We're putting them away — and once out of sight, they are out of the public's mind."

"The businessmen are pressing charges, and we are getting these 'street people' in numbers. Society just doesn't want to have to deal with it anymore. Jails have become caretakers for a population that has long been ignored, and are still being ignored because we're putting them away, out of sight — and once out of sight, they are out of the public's mind."

So it's the police who now have to deal with the deinstitutionalized, Malone claims. "But we're just not geared for it."

Deputies of the Franklin County jail are required to take 80 hours of intensive training, 20 hours of which deal specifically with how to handle prisoners with psychological problems.

A "crisis team," composed largely of experienced deputies, respond to immediate psychiatric emergencies — such as suicide attempts.

"The problem," says Gary Moore, who serves as Training Officer for the State Department of Correction and Rehabilitation, which trains prison guards for the state's facilities, "is that our guards have a wide range of abilities and educational levels, so we have to make our psychological training pretty basic."

State prison guards receive 120 hours of training, some of which is set aside as "interpersonal communication."

"We try to teach the guards that, often, what the prisoner says is not his or her real concern," says Moore, who has a background in education. "We do role-play situations where the trainees attempt to determine what the prisoner's concern is, and thereby de-escalate a volatile situation.

"The professional staff simply can't handle all of the problems," says Moore. "So we are trying to teach the line staff to communicate with the prisoners, and to alert the professional staff if they see any problems."

In the Franklin County Jail, where the ratio is one deputy for 104 prisoners, the situation becomes even more difficult.

"The only way we really know if a prisoner has a psychological problem is if they create a disturbance, or if they are blatently disturbed," says Malone. "We're not qualified to know by looking at them, or talking with them if they are psychologically unbalanced. But if you see a prisoner eating his own feces, you don't have to be a professional to know this man has problems."

And these problems are not going to go away with a weekly counseling session, she continues.

"It's a reflection on today's society as much as anything. We're beginning

to see the effects of years of substance abuse. Criminals are getting sicker. They're more violent, more psychotic. They're not quietly crazy anymore.

"Our cells are beginning to look like the back wards at the Central Ohio Psychiatric Hospital. Everything is the same, they've just changed the address is all. It's the same locked environment, the same oppressive conditions, but there are no longer any institutions. Just us."

And the justice system is left to deal with it all.

"Columbus is unique in that, two years ago, we met of our own volition with judges and attorneys, psychiatrists and social workers to review the situation and establish an awareness of the problem, so that everyone's rights could be retained. We need to protect the rights of those who are incarcerated with us, as much as those in the community whose rights were violated by these people. If they are sick, they need to be where they can receive care," says Malone.

The principle sounds basic, but "at one point," Malone claims, "things were so bad that someone was actually arrested while they were in a mental institution and brought here. Can you believe that? How are we supposed to deal with them when the professionals can't? To me, that's dumping."

Increased awareness has changed that, and now, such incidents are caught and reviewed before they reach such extremes. Both Cleveland and Cincinnati have similar review programs, but theirs were federally mandated, and Malone is proud of the fact that Columbus developed an awareness of the problems, and attempted to solve them on its own. But, she's expecting a change, a shift away from the present process of deinstitutionalization. It may not come right away, she says, "but there is already a ban on group homes in Columbus, and I just think that, in another ten or fifteen years, the community is going to revolt, and we're going to go back to institutions — bigger ones than we had before.

"Perhaps what we need to do is to take a look at different kinds of structured environment," Malone says.

"On paper, deinstitutionalization is a very ideal arrangement, but it just doesn't work. Everyone can't make it in the community . . ."

"We could have four levels of institutions, from very restrictive to less restrictive. The institutionalized could be reviewed every few years, and placed in the level that suits them best.

"It currently costs about $10,000 to keep a prisoner in jail for one year. Surely some of that money could be used to construct facilities which are more suitable for the mentally ill and the mentally retarded than prisons and jails.

"There were abuses under the old system," Malone continues, "but deinstitutionalization has gone too far. The institutionalized have been forced to exchange one drastic environment for another. They can't handle it," Malone says. "And the bottom line is, we can't either." **OSMA**

Karen S. Edwards is Executive Editor of the Ohio State Medical Journal.



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When Do I Refer to a Psychiatrist?

By Daniel Deutschmann, MD

"When should I refer a patient to a psychiatrist?" This is a more difficult question than might be apparent at first glance. It has taken on an even greater significance with the increasing focus on health care costs and the proliferation of alternative health care delivery systems. With PPOs, IPAs and HMOs, the primary care physician gatekeeper will bear the heavy responsibility of deciding who shall be referred for psychiatric evaluation and who shall not.

In the past, it often seemed that those patients who needed referral the most were among the least likely to accept referral while some of those who requested referral were merely the "worried well" who longed to "rent a friend." Then there were the tragedies, the quiet folks that no one ever suspected, who went out and killed themselves or killed their families and then themselves. To make matters worse, the burgeoning growth of medical knowledge has left family physicians with less and less time for the study of psychiatry and the medicine-psychiatry interface.

Half of all patients' visits to physicians are either for problems with an emotional basis or for problems that have a very significant emotional component. While physicians acknowledge this, patients are generally unaware that emotional factors are basic to many of their difficulties.

The astute clinician has three things to guide him or her: 1) clinical judgment, 2) a high index of suspicion and 3) a few significant telltale signs. "Tip-offs" to underlying covert emotional problems may be symptoms out of proportion to physical signs, poor compliance with medical regimens, disturbed family relationships, poor work performance, poor school performance, alcohol and drug abuse, promiscuity, divorce, etc. Certain groups such as the chronically ill and the elderly are at particularly high risks.

What should you, the primary care physician, do when you begin to suspect that your patient has a covert emotional problem? Start by reconsidering the data. Then ask yourself whether the unanswered questions in the case would be less perplexing: 1) if a covert emotional factor were operating or 2) if more were going on in the patient's life than he/she had thus far told you? See the patient again. Find out what was going on when the symptoms began or increased? If questions still remain, obtain additional history from the patient's spouse, child, or parent. Ask the patient if he/she is seeing other doctors. If so, talk to them. This data may be the key to understanding the situation.

As telltale signs of significant covert underlying emotional factors are sought, it is important to find out whether the patient has considered that emotional factors may be operative in his/her situation. If the patient says, "Ya know doc, I figure you're gonna tell me it's all in my head," he/she may be trying to tell you that he/she is coming to this same conclusion! The patient may be able to see a temporal correlation between increased periods of stress and exacerbation of his/her symptomatology.

Next, consider whether the patient will accept a suggestion for psychiatric consultation from you. If you aren't sure, call a psychiatrist you know and ask him/her about your patient's situation. Your psychiatric colleague should not only be able to tell you what confirmatory data to look for from the patient and his/her family but also suggest how you may approach your patient to initiate a referral for consultation.

Depression is one of the most important conditions that may present itself in hidden form to the primary care physician. Some patients will step

continued on next page

forward and identify themselves to their doctors as being "depressed," "tense," "no pep," "no energy," "tired," "need vitamins," "getting old." These are the easy ones. Others will force cheerfulness, force a smile, bury themselves in a flurry of work, chores, volunteer jobs or compulsive activity. The physician's high index of suspicion is his/her most useful tool in spotting these patients.

Other patients may give themselves away as they leave the office: "By the way, ya got something that can give me some pep?" Still other patients will present with physical symptoms for which either no organic source can be found, or for which organic causes seem out of proportion to the patient's subjective complaints. And others will complain of anxiety, anxiety attacks and panic attacks. These often have an abrupt onset and are terrifying to patients. They often feel "the end is at hand." Rapid heart beat, fear of impending death, fear of heart attack, sweating, inability to breathe, light headedness with numbness of the hands and feet, etc., can all be part of these symptom clusters.

Multiple somatic concerns and somatic preoccupation are often present in patients whose principal problem is emotional. It is often very difficult to help these patients understand that we are *not* telling them that they are "crazy." We need to help them understand that we know they "hurt," have the "pain" and are honestly reporting what they perceive.

Our genuine efforts to be clear to our patients in this regard will go a long way towards enhancing our rapport with them. In spite of our efforts, some patients will become indignant and feel we are calling them a "liar." What they can't accept is that the mind and body are interwoven in such complexity that tensions, pressures, conflicts and feelings, particularly those which are recognized, can lead to a variety of physical symptoms. Most of the time these tensions, pressures, conflicts and feelings are either unrecognized by the patient or if recognized are minimized. The patient is almost always unaware of their tremendous significance. Spastic colon, heartburn, indigestion, headache, back pain, — the list goes on and on.

One caveat is in order. Since emotional problems don't protect against physical illness, organic pathology must not be overlooked in caring for these patients. Very often these unrecognized emotional factors augment the suffering of underlying bona fide organic pathology, leading to a disproportion between amount of subjective complaining done by the patient and the extent of the objective physical findings.

Surgery for real organic pathology is often much less beneficial for this group of patients. A "tip-off" here may be a patient's poor clinical response to an otherwise fairly successful surgical procedure. Psychiatric care for the underlying

A Case Study . . .

Bill is a 38-year-old married white father of three. He was referred by his orthopedic surgeon when repeated back surgeries for disc disease left him totally disabled, in constant pain and habituated to synthetic narcotics and minor tranquilizers. An ex-Marine with an outstanding record of bravery and dedication, he had become depressed and frustrated. Out of financial necessity, his wife was forced to work full time to support the family. This was a real blow to this proud, ex-Marine.

He was also very angry at his inability to get relief from the pain and spasms. Many members of the health-care team believed he didn't want to get better and enjoyed bilking the system. He went from doctor to doctor, seeing a family practitioner, internist, orthopedic surgeon and neurosurgeon. He received narcotics and tranquilizers from each, though none knew of the others' existence.

He took his frustrations out on his family, but his older daughter bore the brunt of his anger. She was just entering adolescence and seemed to be a normal, emotionally healthy young woman. He dealt with her reasonable attempts to achieve autonomy with outbursts of rage and Marine Corps-like discipline. Her grades fell, she rebelled and began to experiment with drugs as a way of expressing her upset and striking back at the father.

The patient's wife was upset because her husband wouldn't listen to reason. The patient was quite surprised and somewhat insulted when his highly regarded physician recommended psychiatric consultation.

All the physician really had to go on were: 1) a patient who responded to no treatment, and 2) his excessive demands for pain medication while in the hospital for tests. The physician hadn't been told about the other physicians involved in the patient's care or the tremendous quantity of medication he was taking.

In spite of the patient's hurt and anger at the idea that he should see a psychiatrist, he followed through. Although he did feel that his doctor was saying he was "crazy," the patient accepted an initial appointment. He was extremely anxious, cracked jokes and tried to impress me with his suffering. He threatened to do something crazy, like kill himself or his family, if I didn't give him more drugs to relieve his suffering.

In spite of this defensiveness, he agreed to on-going visits without additional medication. With the passage of time, rapport developed. He began to tell me that he was seeing numerous doctors and receiving multiple medications from each.

Initially he was seen weekly, then every other week and now every eight weeks. First he became less frustrated, then less symptomatic and finally he began to lash out less and be less harsh with his daughter at home. She, in turn, began to be less provocative and defiant towards him. Her grades, as well as her choice of peers at school, improved. She abandoned the drug-abusing crowd.

emotional problem can often help if instituted early enough in the clinical course, before entrenchment takes place.

Patients really do want to feel better and function at a higher level. But when these symptoms become entrenched, being ill becomes a "way of life" and effective therapy is much more difficult to achieve. Early psychiatric intervention can be particularly helpful, not only in relieving pain and improving level of function but also in preventing entrenchment of symptoms as well as addiction to narcotics and habituation to minor tranquilizers.

It is often very difficult to help patients understand that we are not telling them that they are "crazy." We need to help them understand that we know they "hurt," have the "pain" and are honestly reporting what they perceive.

Helping such a patient has numerous benefits. The decrease in morbidity and disability are obvious, but only the beginning. Unnecessary visits to multiple practitioners are avoided; unnecessary hospital admissions for expensive tests, procedures and treatments can be avoided. This leads to substantial health care cost savings. Additional benefits, "ripple effects," are derived by the family. Healthier parents provide their children with more appropriate nurturing and with better role models with whom to identify. The societal, humanitarian benefits and cost savings can be enormous.

Bill's perceptive physician (see "A Case Study") realized that referral was indicated. It took courage to change the patient's anger at the implied insult inherent in suggesting a psychiatric consultation. The patient trusted his doctor when he might not have. Psychiatric expenses were incurred, but medical expenses decreased markedly, morbidity decreased and the patient's sense of well being increased. The patient now functions at a higher level and his daughter's development is back on a healthy track (ripple effect). She will be more likely to make a positive contribution to our society and less likely to get hooked on drugs, drop out of school, have a child out of wedlock, or have other negative experiences.

Health care resources can yield their greatest humanitarian, societal and economic cost benefits when covert emotional factors in clinical situations are assessed properly. The key issue is the possibility that an important covert emotional factor might be operating. Our index of suspicion must be high, particularly when things don't seem to be falling into place. Referral for psychiatric evaluation should be carried out in a timely manner to prevent entrenchment of symptoms. **OSMA**

Daniel Deutschman, MD, practices psychiatry in Cleveland, Ohio.

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(b). A copy of the manuscript should be retained by the Author.

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(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. *The Journal* will assume $10 of this expense and the author will be billed by *The Journal* for the remainder.

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5. **ABSTRACTS.** A *short* (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

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(b). References should be listed in the *order of their appearance in the text.*

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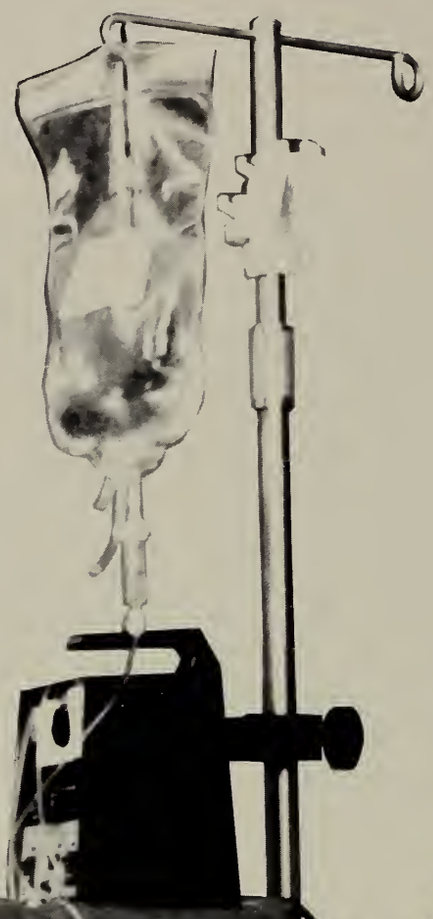
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Recent Developments In The Treatment Of Psychiatric Disorders

By David L. Garver, MD

Major advances in psychiatric diagnosis and treatment now promise reduced psychiatric morbidity for substantial numbers of psychiatric patients.

Lithium In The Treatment Of Bipolar Illness

Only within the past five years has lithium had widespread use in this country. It was initially introduced in 1970 for the treatment of mania. Subsequently, indications for its use expanded to the prevention of further manic episodes. Finally, it became certified for the prevention of depressive episodes associated with bipolar (manic-depressive) disease as well. It is now known that 80% of patients with bipolar disease can expect that their disorder will be virtually eliminated symptomatically as long as proper lithium prophylaxis is maintained.

Numerous family and genetic studies have demonstrated that bipolar disease breeds true. That is, the diagnosis of possible bipolar disease can often be made early in the life history of a disturbed child, adolescent or young adult on the basis of mania in a close relative. We are learning that some forms of hyperactivity in prepubertal children may be successfully treated not with stimulants, but as a precocious form of familial bipolar disease, with lithium. Similarly, adolescents in families with mania (bipolar illness) may disguise the presentation of dysphoric mood states with drug abuse, antisocial behavior as well as frank schizophrenic-like psychosis. Whenever mania appears in a patient's family, it is now important to rule out the possibility of a lithium-responsive symptomatic variant of bipolar disease in a symptomatic child, adolescent or related adult. The rule out of such a disease may require a lithium trial.

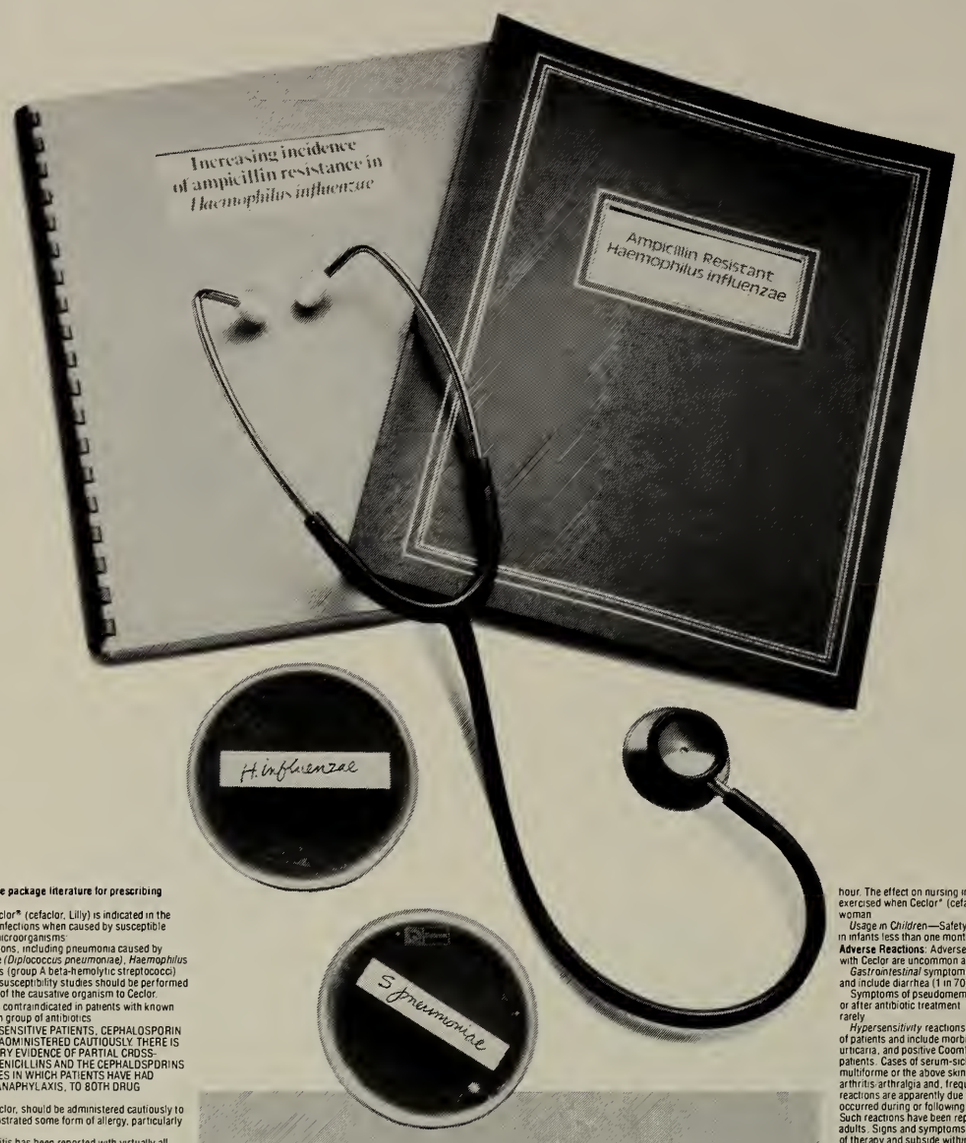
Diagnosis Of Psychiatric Disorders Responsive To Lithium

Symptomatic variants of bipolar disease are being described in adults as well as in children. Here there appears to be at least a modest revolution in psychiatric diagnosis which is substantially improving the application of treatments. Kraeplin wisely divided major psychiatric disorders by course into chronic deteriorating (schizophrenia) vs. episodic (the affective disorders). The majority of American psychiatry, however, lost touch with such course distinctions in its quest for pathognomic symptoms or symptom complexes as the basis of diagnosis and treatment. Moreover, until the 1970s only two types of pharmacologic intervention (other than sedation) were possible: antidepressant and/or antipsychotic drugs. Each group of drugs was directed against characteristic symptoms: depressed mood or disordered thinking (though antipsychotics were also regularly used in mania). The observation that a new treatment (lithium) substantially improved psychotic symptoms in some schizoaffective and even acute schizophrenic disorders spurred investigators on into the genetics of psychosis, differential course of separate psychotic disorders (chronic vs. episodic), and appropriateness of drug treatments. Today we recognize that some episodic, schizophrenic-like psychotic disorders are not schizophrenia at all, but rather are an atypical presentation of an illness which bears many similarities to bipolar illness — antipsychotic response during acute lithium treatment and prevention of future episodes during continued lithium prophylaxis. This has been recognized by the distinction between affective-mood-incongruent-psychoses and schizophreniform disorder on the one hand, and schizophrenia on the other in the 1981 revision of the nomenclature (DSM-III) by the American Psychiatric Association.

Such diagnostic distinctions and their consequent treatment

continued on next page

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor* (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGDT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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implications have been strengthened further by the disturbing long term effects of classical drugs. Tardive dyskinesia has emerged as the scourge which sometimes accompanies the benefits of the long term use of classical antipsychotic drugs. This persistent movement disorder involved the perioral musculature (tongue, lips, jaw) with rhythmic movements; tics occur throughout the body. Advanced tardive dyskinesia involved a host of trunkal muscle systems with consequent choreiform movements. Mild tardive dyskinesia occur in approximately 20% of patients following long term antipsychotic (neuroleptic) drugs. Though there are presently no controlled studies to verify the impression of numerous investigators, many are impressed that an even higher rate of dyskinetic movements occurs in patients with episodic (affective) disorders who have been (many times improperly) maintained on antipsychotic drugs.

Advances In The Use Of The Laboratory

Though there have been no new breakthroughs in the treatment of unipolar depressive disorders, the contribution of the clinical laboratory is being strongly felt in refining psychiatric treatment. The relationship between plasma levels of several commonly utilized tricyclic antidepressant drugs and therapeutic (antidepressant) response has been defined. Clinicians using nontriptyline or imipramine may confidentally adjust drug dose so as to achieve therapeutic plasma levels. Utilizing such laboratory services, response rates to these drugs can be increased from 70% (without such routine drug dose adjustment) to 90% to 95% in appropriately selected endogenous depressive patients — response rates comparable to those achieved in a similar (non-psychotic) population by ECT. Unfortunately, therapeutic ranges have still not been well defined for the majority of other commonly used antidepressant drugs.

New Treatment For Panic Disorder

Considerable interest has been growing in fresh ways to treat/prevent anxiety states. Panic attacks have been of special interest. Several studies have suggested that panic attacks commonly occur in families who also have members with affective disorder(s). The prevention of panic attacks by the majority of antidepressant drugs now gives additional support to the suggestion that such panic anxiety is closely related biologically to such affective disorders. Recent evidence suggests that the early treatment of panic attacks by antidepressants prevents the development of associated phobias and secondary depression.

Pharmacologic Control Of Drug Withdrawal Symptoms

Withdrawal anxiety/dysphoria in opiate addicts appears largely preventable in utilization during the withdrawal phase of the alpha-2-noradrenergic agonist, clonidine. The clinical usefulness of clonidine in preventing such withdrawal anxiety/dysphoria was discovered as a result of an excellent series of studies of central norepinephrine systems and anxiety. Hyperactivity of central norepinephrine systems was found to be associated with opiate withdrawal symptoms in laboratory animals. Clonidine was found to suppress such noradrenergic hyperactivity and the associated hypervililant, dysphoric state in animals. Clinical trials of clonidine in patients undergoing opiate withdrawal demonstrated its effectiveness in suppressing the withdrawal syndrome.

On the Horizon

Animal studies are currently suggesting that within several years we may have anxiolytic agents which are without sedative properties. Such expectations are coming out of studies of central benzodiazepine receptors and receptor subtypes. Recent work has suggested that the group of benzodiazepine receptors which modulate anxiety states can be discriminated from those modulating alertness/sedation, from receptors which modulate muscle tone and from benzodiazepine receptors which are associated with antiepileptic effects. Selective agonists and antagonists of each of the four subtypes of the benzodiazepine receptors are being developed and tested. It is anticipated that drugs will soon be developed and marketed which produce anxiety relief without sedation, and drugs which maintain alertness without the dysphoric anxiety of classical stimulants.

A new generation of antidepressant drugs are also just around the corner, a generation of antidepressants which are apparently free of anticholinergic, hypotensive and cardiotoxic effects, yet are equal in antidepressant efficacy to currently used antidepressant drugs. Several such drugs are currently being examined by the FDA for possible approval and release in 1984/85.

The developments of the past and present decade bode well for continued advances in the diagnosis and treatment of the mentally disabled. **OSMA**

David Garver, MD, is professor of psychiatry, pharmacology and cell biophysics at the University of Cincinnati, College of Medicine, and practices psychiatry in Cincinnati, Ohio

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Marketing Mental Health

By Susan Porter

Today's mental health professional faces a unique set of problems in offering his or her services to the general public. Whether they are a psychiatrist in private practice, a psychiatric consultant to a community mental health center or social service agency, or a full-time staff member at a psychiatric hospital, their problems in reaching the mainstream of America are similar, due not only to ambivalent public attitudes towards mental illness, in general, but also to major changes in the funding of community mental health programs.

"Seeing a psychiatrist is not like discussing a physical problem with your family doctor," says Barbara Braham, director of the North Central Institute in Columbus, who recently led a seminar on "Marketing Mental Health Services to the Private Sector." She explains, "A patient with heart problems or cancer does not feel at fault for that problem. But with many mental problems, there is some blame attached. The public has a negative view and tends to associate 'mental health' with 'crazy.' Many people want to stay as far away from it as possible."

The problems are further intensified by financing. While patients may be charged anywhere from $50 to $100 an hour for psychiatric consultation, some insurance policies cover only part of the fee and some none at all, putting mental health care financially out of the reach of many Americans.

Make sure you have a top quality service or program to offer before you attempt to market it. Work all of the bugs out of any new programs before taking them to the public.

"Twenty years ago, the poor who could not afford care were committed to state institutions," says Braham. "However, there was very little available to the middle-class citizen who could not afford private care."

Then in 1963, the late President John F. Kennedy signed into law the Community Mental Health Center Construction Act, allocating federal funds for the creation of community mental health centers which would offer affordable services to citizens in their local communities. To date over 700 of these centers have been opened nationwide, providing a variety of services, from 24-hour emergency care and day treatment programs, to rape prevention, aftercare and even psychiatric hospitalization. They also have employed a variety of mental health care professionals, often contracting with those in the private sector for special services. In essence, says Braham, they have helped to bring mental health services to the attention of many more Americans.

Some centers, however, still suffer from negative images and many today are facing serious financial problems, brought on chiefly with the reorganization of the federal government and the establishment of the Department of Health and Human Services. In 1981, The Community Mental Health Systems Act was repealed and funding was replaced by The Alcohol, Drug Abuse and Mental Health Block Grant. "These block grants were not equal to what the centers were receiving," says Braham,

"so most agencies have been forced to undergo major changes and cutbacks. We're having to find a wider variety of payor sources (businesses, insurance, individuals, private grants) and we're beginning to market our services to a wider variety of clients."

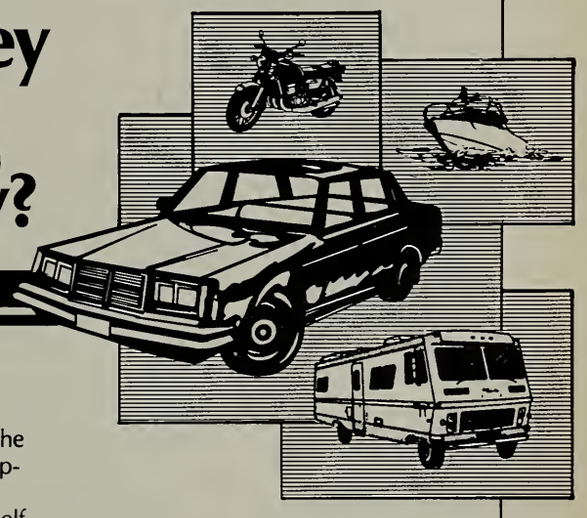
The result is that community mental health agencies are having to work harder to develop new programs and to attract clients who want and can afford to pay for these services. For the North Central Institute, a division of the North Central Community Mental Health Center in Columbus, this has meant time and stress management seminars aimed at the business community, consultation and educational services provided private industry, and various other "psycho-social" services aimed at the general public. It also has meant a more careful and thorough marketing program, aimed chiefly at diminishing negative attitudes towards mental health care.

Braham, who has developed such a program for the institute, suggests the following tips to all mental health professionals interested in seeing their programs and services used by a broader range of clients:

- Give careful thought to how you label your services and programs. Because, for many people, mental health still holds a somewhat negative connotation, it may be best to advertise "professional services" or "counseling services." Also, the name of your practice or agency should accurately reflect your focus and specialties.
- Offer your services during hours when your patients can best take advantage of them — even though this may entail evening and weekend hours for you.
- Define the image you want to present to the public and to your potential patients. This will largely depend on that segment of the market you wish to attract. For instance, if your services are aimed at adolescents and young adults, your dress, office decor and even your receptionist should relate to this age group. If you are dealing with older adults, you will want to take an entirely different approach.
- Develop new programs and services on an incremental basis. Don't make a lot of changes all at once, or you're likely to upset and confuse your staff — not to mention your current patients.
- Make sure you have a top quality service or program to offer before you attempt to market it. Work all of the bugs out of any new programs before taking them to the public. Remember, a satisfied patient may tell a friend or two about your services; a dissatisfied one will tell at least six. And one bad program may bring negative attention to your entire operation.
- Explore cooperative ventures with other professionals. Team up with other psychiatrists or mental health professionals to offer workshops, educational programs and other special services. You may even want to work with physicians outside of mental health for patient consultation and referral.
- Confidentiality is the golden rule of mental health care; while you may take this for granted, your patients may not. Assure them that what they tell you is private. Also, inform your staff that they are not to discuss clients among themselves. If a patient overhears your receptionist talking about another patient, he or she won't trust you, either.
- Remember, you're selling an intangible service. "When people pay $50 for a Texas Instruments Home Computer, they can see what it is they're getting for their money," Braham says. "When they're buying an hour of your time, you have to work harder to let them know you're offering them something they really need." **OSMA**

Susan Porter is Assistant Editor, the Ohio State Medical Journal.

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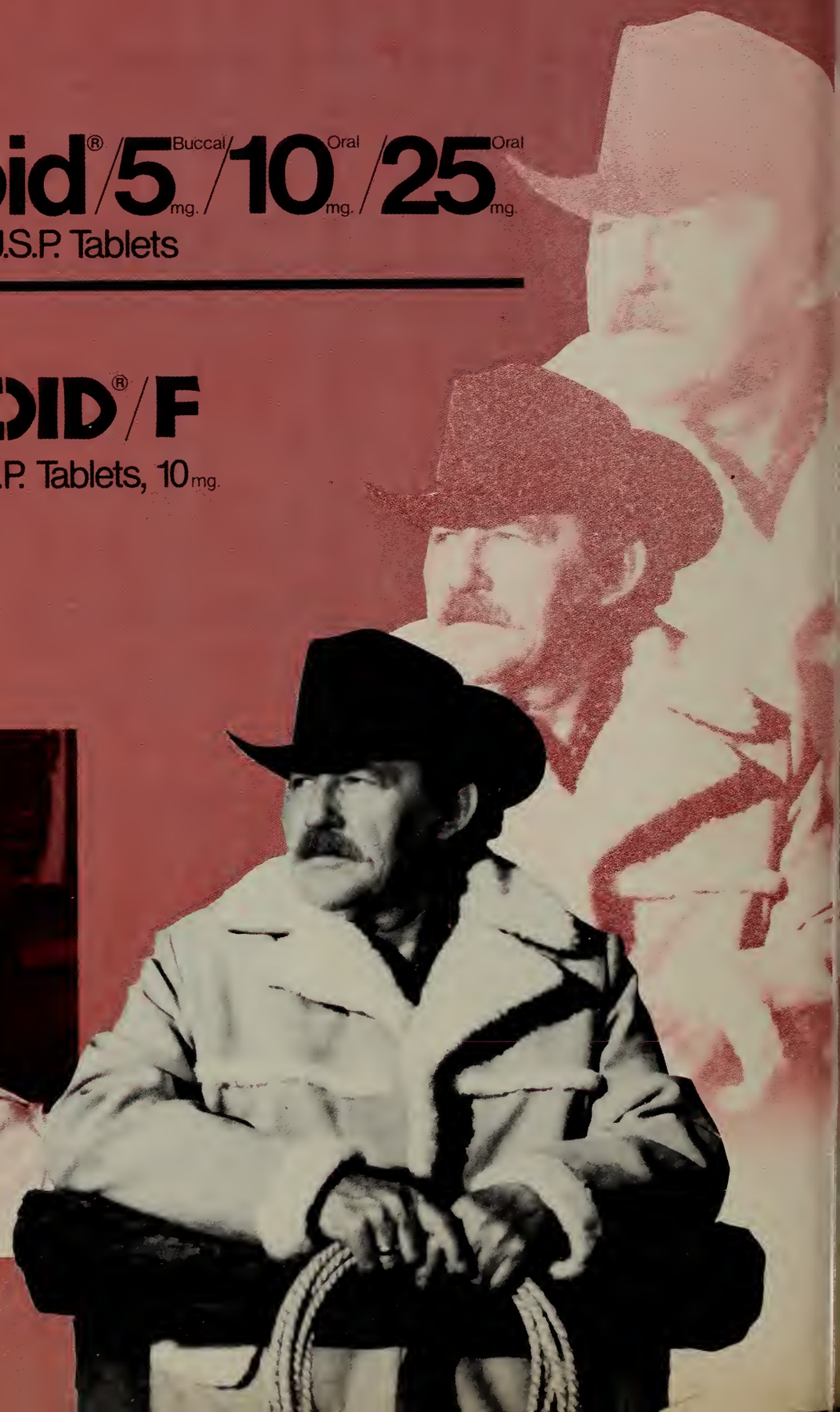
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My Brother's Keeper

By Corwin M. Smith, MD

Since its inception on July 1, 1975, the Physician Effectiveness Program (PEP) of OSMA has served to assist physicians who are impaired or disabled. Although there are myriad diseases and disabilities, the primary force of our efforts is directed at chemical dependency (both alcoholism and drug dependency) and psychiatric problems. Chemical dependency is, by far, the most prevalent of the diseases or disabilities to be confronted by PEP. With proper and adequate treatment, the prognosis is normally encouraging.

PEP is operated by physicians who are appointed by the OSMA President to the Committee on Impaired Physicians. This committee serves as an adjunct of the OSMA Committee on Mental Health.

Members are assigned a geographical area and given the title of District Liaison Physician (DLP). For example, a DLP in Cleveland might be assigned to Cuyahoga, Lake and Geauga Counties. A DLP in Columbus might be assigned to Franklin, Delaware and Pickaway Counties.

Three major options are outlined under the Physician Effectiveness Program. The first, called "Individual Initiative," is followed when the sick physician, himself or herself, seeks guidance and referral through OSMA. This procedure is relatively simple: OSMA links the sick physician with a DLP who helps him or her obtain the proper treatment, thus ending OSMA's involvement.

Options Two and Three involve "Peer Initiative" and are much more complex. Under both of these options, a concerned peer (generally, another physician practicing in the same community) recognizes the possibility that a fellow physician might be ill and in need of assistance and contacts PEP through OSMA. The concerned peer should be prepared to identify the colleague he or she feels may be in trouble, as well as himself or herself, although anonymity will be guaranteed the helping physician and anyone else who might get involved in the process.

We are now in the process of addressing the problems of physicians impaired by senility. We hope to work in close cooperation with geriatric medicine as that branch comes to the fore.

Next, the local medical society is contacted by a staff person to further determine if the person reported has a problem. If sufficient evidence exists, a DLP is assigned to the case, who then reports the matter to the PEP chairman.

The initial contact with the impaired physician is made in writing by the chairman, explaining the nature of the program, the general circumstances leading to the letter and stressing the desirability that the physician seek appropriate evaluation and treatment. The letter explains that a DLP will soon contact the physician to help make appropriate arrangements for treatment.

Shortly thereafter, the DLP makes personal contact with the physician and offers to lend assistance. If the physician in question acknowledges the problem and need for assistance, "Option Two" is followed: the DLP helps make the necessary arrangements and the sick physician enters treatment with an attending physician.

If, however, the physician in question denies any illness, refuses assistance or fails to complete the treatment, "Option Three" goes into effect. The DLP reports the circumstances to the chairman, who after a suitable interval again writes the physician in question, urging him or her to seek assistance and pointing out the program's responsibility to report the situation to the Ohio State Medical Licensing Board if no corrective action is taken voluntarily.

The DLP follows with telephone contact, stressing the same points. If the physician in question still denies

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Columbus 43212
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Northeast Office:
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Suite 106, 23360 Chagrin Boulevard
Beachwood 44122,
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Perrysburg 43551,
(419) 874-8080

Denial is the foremost symptom of most impairments. We must do everything possible to convince the impaired physician that he is impaired — and that treatment and rehabilitation will provide him an avenue to return as an effective, productive member of the medical community.

illness or declines assistance, the DLP again reports to the chairman who, in turn, communicates the facts of the case to the Ohio State Medical Board. At this point, OSMA's involvement ends.

Under all three options, successful completion of treatment may be followed by special counseling and assistance in re-entering medical practice, provided by PEP.

In line with policy adopted by OSMA Council, no official records are kept by PEP. Thus, statistics of successes and failures are not available. The decision to avoid record-keeping is based on present state statutes, as well as a desire to maintain strictest confidence within the program among the impaired physician, the DLP, and the treating physician.

In addition, it is important to note that PEP is not in a competitive situation. We cooperate to the fullest extent with impaired physician programs in other states. Our DLPs have the option of suggesting treatment facilities either within Ohio or in other states.

In eight years we have made several modifications in PEP. We are now placing additional emphasis on advocacy — as more and more physicians are completing the initial phases of treatment and reentering the work force of medical practice.

We are now in the process of addressing the problems of physicians impaired by senility. We hope to work in close cooperation with geriatric medicine as that branch comes to the fore.

We are maintaining a close liaison with the Ohio Medical Education and Research Foundation (OMERF). Within OMERF is the Perry R. Ayres Memorial Fund which, in the near future, will initiate low interest loans for physicians who have been financially devastated during the impairment process.

The OSMA Physician Effectiveness Program is designed to assist our impaired colleagues in recognition, diagnosis, treatment, rehabilitation, and advocacy during re-entry.

Denial is the foremost symptom of most impairments. We must do everything possible to convince the impaired physician that he or she is impaired — and that treatment and rehabilitation will provide him or her an avenue to return as an effective, productive member of the medical community.

We concern ourselves with sick doctors — not bad doctors. Each case is individually handled, taking into account the specifics of the disease and his or her needs for treatment. We are intentionally not geared for treating all impaired physicians identically and sending them to a single treatment facility.

Our liaison with the Ohio State Medical Board took on new significance during the past year — by virtue of the outstanding leadership of Oscar W. Clarke, MD. Cooperation between PEP and the board is essential for the overall success of the program.

We are grateful for the mandate given us by OSMA Council. Those of us who are recovering are especially grateful for the opportunity to pass onto others what was so generously given to us — the gift of a new life.

Recovery is contagious!

Editor's Note: To contact PEP, call 614/228-6971. **OSMA**

Corwin M. Smith, MD, Cincinnati, is Chairman, Committee on Impaired Physicians, OSMA Physician Effectiveness Program (PEP).

Next month in:

THE Ohio STATE Medical Journal

The Elderly

They are not just patients anymore. They are fast becoming a new, more active, more vocal group . . . and their numbers are increasing daily.

The program would operate thus: A Medicaid recipient in a given rural county will select a primary sponsor physician who has agreed to be involved in the system. The sponsor will be responsible for providing all primary care services for which the recipient is eligible, and will control the recipient's access to other care . . .

Rural Health and Medicaid

This report was compiled by staff members of the Ohio Department of Public Welfare.

In an effort to establish a primary-care case management system in rural counties, the Ohio Department of Public Welfare (ODPW) is recommending a program that would be a type of primary care network that pairs a recipient with a physician, who would be responsible for providing or authorizing all medical services that the individual receives. This creates for the Medicaid recipient a "family doctor" who will manage his or her care and treatment.

The goals of this program are to:

- Provide Medicaid recipients with an assured access point to mainstream primary care.
- Provide for greater continuity of care between a recipient and a physician.
- Ensure that a physician will have total control over the treatment plan of a recipient.
- Increase the number of physicians who will provide services to Medicaid recipients.
- Better manage recipient use of medical services.
- Reduce levels of hospital inpatient and emergency room service utilization.
- Contain costs in the Medicaid program.

It is clear that a case management program of this type must be considered an experiment, and initially treated as such. The program would operate in the following manner: a Medicaid recipient in a given rural county will select a primary sponsor physician who has agreed to be involved in the system. The sponsor will be responsible for providing all primary care services for which the recipient is eligible and medically needs, and will control the recipient's access to other care by giving prior authorization for all necessary non-emergency care that is provided by other physicians, specialists, clinics, hospitals, and other providers, and all services such as laboratory, radiology, and pharmacy. Arrangements must be made by the sponsor for the availability of 24-hour access to approved care for a recipient to cut down on unnecessary trips by recipients to hospital emergency rooms when consultation with a physician is not available. This is a key part of the overall goal of having appropriate services available for recipients in the appropriate setting. Actual medical or accidental emergencies will not be restricted to prior authorized services; necessary immediate care will be covered in all emergency cases.

There are two basic alternatives that the state would like to consider as implementation options for the program. The first is a basic approach under which physicians would continue to receive payment on the traditional fee-for-service basis for care they provide to a recipient, and would also be paid a monthly case management fee for each Medicaid recipient for whom they agree to serve as case manager/primary sponsor. The exact level of the fee has not been determined. Specialists and other providers to whom the primary sponsor authorizes referral for a

recipient's care will continue to be paid under the fee-for-service standards as they are now.

The second option would involve the payment of a case management fee at a lower level than in the first alternative, in addition to normal fee-for-service reimbursements, but would also include a sharing with primary sponsor physicians of savings that result from the impact of the program. This would *not* be a risk sharing or risk based system in which involved physicians would be at risk for the service utilization of an individual recipient, and thus, potentially be liable for the cost of services that exceed historical averages. This would simply be a payment to case managers of some percentage (25% perhaps) of the cost of services that are the difference between historical utilization levels and the reduced service levels resulting from the implementation of case management controls. This would provide a direct incentive for physicians to control recipients' overuse of services, and allow the program to "pay for itself" out of directly attributable savings.

Though this type of payment program would be difficult to administer on the level of individual physicians or recipients, it would more easily be managed on an aggregate level. This type of option could effectively be introduced in dealings with a clinic or similar group medical practice that sponsors a large cross section of an area's Medicaid recipients.

Physicians best suited for the role of primary sponsor are general practitioners, family practitioners, pediatricians, internists, and obstetricians/gynecologists. Specialists may be designated as primary sponsors, but they will be responsible for providing their recipients with primary care. A group practice or clinic may be the sponsor, providing that a single individual physician is specified as the primary access point to care, and that all other physicians in the practice or clinic have acccess to the recipient's medical chart to ensure the provision of a consistent care and treatment program.

The program seems to have incentives for participation by both recipients and physicians. While a recipient would be restricted to one provider from or through whom he/she may receive primary care services, the restriction should not impair access to services on a regular or emergency basis. In fact, the recipient would have an assured access point to primary care, in light of the fact that many physicians will not accept any Medicaid recipients, or any more beyond their existing caseload. Recipients could also potentially receive better care, due to the continuity factor of dealing with only one physician on an ongoing basis.

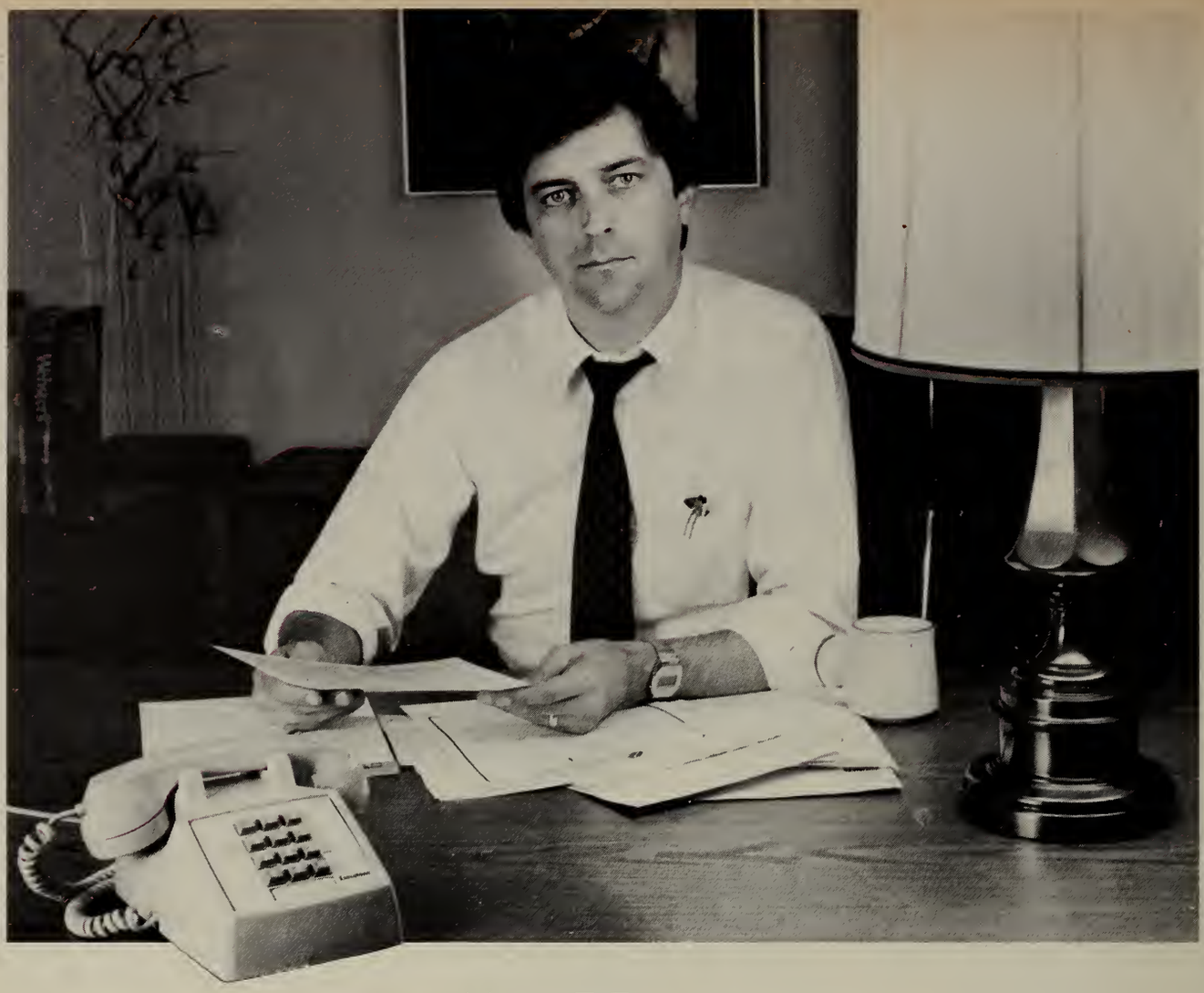
Physicians agreeing to serve as primary sponsors would receive the benefits of a guaranteed clientele, total control over the care and treatment plan of an individual, and the case management fee: a dollar amount paid monthly for each individual recipient for whom the physician accepts responsibility. The aggregate case management payment will be issued to primary sponsors at the beginning of each month, providing them with cash flow advantages. The option of sharing in the dollar value of savings that accrue is also a considerable benefit, since it has the potential of redistributing more of the health care dollar to the primary physician. Acceptance of sponsorship does not require a physician to see each recipient each month, but simply to control his treatment plan and provide medically necessary services. The sponsor will not be required to prior authorize dental, vision, or inpatient psychiatric services. And once referral to a specialist is made, the primary sponsor does not need to be notified if the specialist prescribes drugs or laboratory/radiological tests. However, the primary sponsor must be notified by the specialist if a hospital admission is deemed necessary.

The selection of target counties for the implementation of a pilot case management program will be made on the basis of favorable cooperation from the involved parties (the medical community, county welfare departments, and Medicaid recipient), the goal of focusing on rural counties, and the objective of testing the premise that a case management system can lead to decreased utilization of Medicaid services. For the purpose of this program, a county can be defined as being rural if it contains no city that has a population of 25,000 or more. This includes 61 of Ohio's 88 counties, and is used because of the relationship between population density in an urban area and access to primary physician and institutional care. The use of this measure allows the pilot project to concentrate on medically underserved rural sections of the state.

The case management concept in general is one that combines access and service delivery improvements for recipients while providing clientele, stability, and payment benefits for providers. In addition, potential cost savings exist for the state. As ODPW is in the initial stages of examining the case management concept, a number of questions/considerations/potential problems exist:

- What should the level of the case management fee be, and on what basis should it be determined (under both scenarios of with and without sharing of savings)?
- Will having only ADC recipients involved cause difficulty for providers in dealing with ABD (aged, blind, and disabled) or GR (General Relief) recipients in the target counties? Should these groups be included at the onset of the program or at some later point?
- How should target counties be chosen? The methods described in this paper are options, as are criteria of the numbers of hospital beds or physicians per county. And, how many target counties should be selected for the pilot program? A modest program could start with five counties.
- Is the phenomenon of physicians increasing the number of hospital admissions and lengths of stay to help support rural hospitals and ensure their fiscal solvency strong enough to negate any potential

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Physicians agreeing to serve as primary sponsors would receive the benefits of a guaranteed clientele, total control over the care and treatment plan and the case management fee: a dollar amount paid monthly for each individual recipient for whom the physician accepts responsibility.

benefits or savings from a case management program? (The magnitude of the problem is demonstrated by the fact that between 1972 and 1982, 315 community hospitals closed, 86.5% of them being institutions with 100 or fewer beds.)

- Do a small number of physicians or clinics in rural areas provide most services currently for Medicaid recipients, so that any program of this type will simply be a windfall gain for those physicians without increasing participation or changing the manner in which services are provided?
- Should penalty clauses relating to partial payment of case management fees or disenrollment of providers be included to ensure that levels of utilization by enrolled recipients actually decline or at least do not rise? (This could be considered as a secondary source of savings, in addition to control of recipient overutilization: a mechanism for the disenrollment of high cost providers.)
- Should limitations be placed on the number of Medicaid recipients for whom one physician may be a sponsor, or the dollar value of case management fees that one physician may receive (so to help ensure the continued availability of mainstream care for recipients)?

OSMA

RURAL COUNTY TARGET OPTIONS

	Inpatient Hospital Utilization Rate	Seven Service Lines Utilization Rate
High	Columbiana	Van Wert
	Geauga	Geauga
	Brown	Columbiana
	Washington	Brown
	Ottawa	Delaware
	Crawford	Highland
	Tuscarawas	Ottawa
	Fulton	Miami
	Ashtabula	Ashtabula
	Miami	Warren
Low	Fayette	Henry
	Athens	Holmes
	Preble	Ashland
	Hocking	Perry
	Henry	Hocking
	Ashland	Noble
	Perry	Jackson
	Jackson	Monroe
	Vinton	Fayette
	Holmes	Putnam
Average	Warren	Defiance
	Knox	Knox
	Clermont	Morrow
	Madison	Clinton
	Adams	Hardin
	Seneca	Harrison
	Shelby	Belmont
	Morrow	Adams
	Morgan	Paulding
	Sandusky	Huron

OHIO STATE MEDICAL ASSOCIATION

Account:	01 Admin.	02 Educ. Speclty. Soc. Mtg. Mgmt.	03 Health Ed.	04 Field Serv.	05 Fiscal Mbrshp.
Furniture & Equipment	$ 0	$ 4,215.00	$ 100.00	$ 350.00	$ 15,400.00
Accounts Payable: OMERF	0	0	0	0	0
Term Debt: Current	829.00	3,140.00	776.00	1,147.00	2,646.00
Journal: Publication Cost	0	0	0	0	0
Salaries & Ins. Benefits	208,877.00	233,114.00	71,419.00	73,665.40	225,953.00
Staff Development	50,000.00	0	0	0	0
Staff Expense	12,000.00	11,000.00	3,900.00	8,112.00	12,000.00
President Expense	12,000.00	0	0	0	0
President-Elect Expense	6,000.00	0	0	0	0
Officer Honorariums	19,000.00	0	0	0	0
Council Expense	55,000.00	0	0	0	0
AMA Del/Alt Expense	0	0	0	0	0
Student Business Section	0	0	0	0	0
Ad Hoc: Long Range Plan	0	0	0	0	0
Committee: Ad Hoc Delegate	0	0	0	0	0
Committee: AMA-ERF	0	0	0	0	0
Committee: Art & Culture	0	0	0	0	0
Committee: Audit & Apprtn.	0	0	0	0	38,000.00
Committee: Cancer	0	0	750.00	0	0
Committee: Editorial Board	0	0	0	0	0
Committee: Education	0	9,400.00	0	0	0
Committee: Emrgcy. & Disas.	0	3,200.00	0	0	0
Committee: Cost Effective	0	0	0	0	0
Committee: Envirn. Liaison	0	0	1,000.00	0	0
Committee: Geriatric Med.	0	0	0	0	0
Committee: Govt. Med. Care	0	0	0	0	0
Committee: Hlth. Manpower	0	0	1,500.00	0	0
Committee: Hlth. Planning	0	0	0	0	0
Committee: Hosp. Relations	0	0	0	0	0
Committee: Hlth. Pln. Advisory Panel	0	0	0	0	0
Committee: Jails & Prison	0	0	0	0	0
Committee: Judicial/Prof.	0	0	0	0	0
Committee: Matrnl./Neonatl.	0	0	0	0	0
Committee: Members Ins.	0	0	0	0	0
Committee: Membership	0	0	0	0	0
Committee: Mental Health	0	0	5,000.00	0	0
Committee: Non-Dues Income	0	0	0	0	0
Committee: Prof. Liab. Task	0	0	0	0	0
Committee: Sports Med.	0	0	4,500.00	0	0
Committee: Communications	0	0	0	0	0
Committee: School Health	0	0	2,000.00	0	0
Committee: Stdy. & Rev. Act	0	0	0	0	0
Committee: On Program	0	600.00	0	0	0
Committee: Special Educ.	0	0	0	0	0
Committee: State Legis.	0	0	0	0	0
Task Force On Medicaid	0	0	0	0	0
Task Force: Hlth. Care Mkt.	0	0	0	5,000.00	0
Annual Meeting	0	137,450.00	0	0	0
Bad Dept Expense	0	0	0	0	0
Building Expense	3,353.45	12,700.30	3,139.40	4,637.75	10,702.50
Car Lease	18,000.00	3,200.00	4,000.00	3,600.00	3,200.00
Contributions	0	0	0	0	0
Councilor Dist. Conference	6,000.00	0	0	0	0
Data Processing	0	0	0	0	60,000.00
Depreciation Expense	2,990.00	4,944.00	1,222.00	1,805.00	63,166.00
Equipment Lease & Supply	5,491.86	9,895.71	2,227.83	3,315.84	8,807.70
Equipment Maint. Agreement	0	0	0	0	0
Emergency Fund	50,000.00	1,000.00	1,000.00	1,000.00	3,000.00
Insurance and Bonding	15,175.00	1,075.00	1,075.00	1,075.00	1,100.00
Interest Expense	326.00	1,235.00	305.00	451.00	1,040.00
Legal Expense	0	0	0	0	0
Library	1,150.00	150.00	150.00	250.00	750.00
Meeting Expense	22,500.00	0	0	3,300.00	0
Misc. Supplies	848.00	1,528.00	344.00	512.00	1,360.00
OSMAgram	0	0	0	0	0
Pension Expense	5,800.00	12,000.00	4,000.00	4,000.00	12,800.00
Postage	2,817.00	5,076.00	1,143.00	1,701.00	7,518.00
Printing & Office Supply	4,028.00	7,258.00	1,634.00	2,432.00	10,460.00
Prof. Relations Activity	655.40	1,655.40	1,955.40	655.40	655.40
Public Relations Expense	0	0	0	0	0
Taxes: Payroll	11,145.00	16,493.00	4,078.00	4,890.00	15,383.00
Taxes: State & Local	0	0	0	0	0
Telephone & Telegraph	5,157.96	9,294.06	2,092.38	3,114.24	8,272.20
TOTAL 1984 BUDGET	$519,143.67	$489,623.47	$119,311.01	$125,013.63	$502,213.80

1984 BUDGET ALLOCATION ALL DEPARTMENTS

06 Govt. Relations	07 Communications	08 Development & Member Services	09 State Legislation	10 Legal Services	11 Rental Area	1984 Budget Totals
$ 300.00	$ 4,500.00	$ 2,407.00	$ 0	$ 650.00	$ 0	$ 27,922.00
0	0	20,800.00	0	0	0	20,800.00
1,164.00	1,887.00	1,129.00	1,641.00	1,270.00	2,011.00	17,640.00
0	195,000.00	0	0	0	0	195,000.00
95,657.40	188,386.00	120,566.20	120,295.50	127,453.70	0	1,465,387.20
0	0	0	0	0	0	50,000.00
13,000.00	12,000.00	7,000.00	37,000.00	28,750.00	0	144,762.00
0	0	0	0	0	0	12,000.00
0	0	0	0	0	0	6,000.00
0	0	0	0	0	0	19,000.00
0	0	0	0	0	0	55,000.00
0	0	97,144.00	0	0	0	97,144.00
0	0	15,000.00	0	0	0	15,000.00
0	0	0	0	0	0	0
0	0	1,151.00	0	0	0	1,151.00
0	0	0	0	0	0	0
0	400.00	0	0	0	0	400.00
0	0	0	0	0	0	38,000.00
0	0	0	0	0	0	750.00
0	400.00	0	0	0	0	400.00
0	0	0	0	0	0	9,400.00
0	0	0	0	0	0	3,200.00
1,600.00	0	0	0	0	0	1,600.00
0	0	0	0	0	0	1,000.00
1,500.00	0	0	0	0	0	1,500.00
1,800.00	0	0	0	0	0	1,800.00
0	0	0	0	0	0	1,500.00
1,700.00	0	0	0	0	0	1,700.00
0	0	0	0	0	0	0
500.00	0	0	0	0	0	500.00
0	0	0	250.00	0	0	250.00
0	0	0	0	200.00	0	200.00
2,000.00	0	0	0	0	0	2,000.00
0	0	2,050.00	0	0	0	2,050.00
0	0	1,800.00	0	0	0	1,800.00
0	0	0	0	0	0	5,000.00
0	0	3,500.00	0	0	0	3,500.00
0	0	0	0	0	0	0
0	0	0	0	0	0	4,500.00
0	400.00	0	0	0	0	400.00
0	0	0	0	0	0	2,000.00
1,800.00	0	0	0	0	0	1,800.00
0	0	0	0	0	0	600.00
0	0	0	0	0	0	0
0	0	0	2,000.00	0	0	2,000.00
3,500.00	0	0	0	0	0	3,500.00
0	0	0	0	0	0	5,000.00
0	0	0	0	0	0	137,450.00
0	500.00	0	0	0	0	500.00
4,709.10	7,634.45	4,566.40	6,635.55	5,137.20	8,133.90	71,350.00
6,500.00	3,200.00	6,400.00	3,200.00	3,200.00	0	54,500.00
0	0	0	0	0	0	0
0	0	0	0	0	0	6,000.00
0	0	0	0	0	0	60,000.00
1,833.00	2,972.00	1,778.00	2,583.00	2,000.00	1,482.00	86,775.00
3,315.84	7,719.69	3,315.84	4,403.85	3,315.84	0	51,810.00
0	0	0	0	0	0	0
1,000.00	0	0	1,000.00	500.00	0	58,500.00
1,100.00	1,100.00	1,100.00	1,100.00	1,100.00	0	25,000.00
458.00	742.00	444.00	645.00	499.00	791.00	6,936.00
0	0	0	0	95,000.00	0	95,000.00
650.00	150.00	150.00	2,650.00	1,950.00	0	8,000.00
0	1,000.00	0	0	1,000.00	0	27,800.00
512.00	1,192.00	512.00	680.00	512.00	0	8,000.00
0	45,000.00	0	0	0	0	45,000.00
8,000.00	10,400.00	6,400.00	6,400.00	7,200.00	0	77,000.00
1,701.00	11,460.00	1,700.00	2,259.00	1,700.00	0	37,075.00
2,432.00	5,662.00	2,432.00	13,230.00	2,932.00	0	52,500.00
655.40	655.40	655.40	655.40	655.40	0	8,854.00
0	70,000.00	0	0	0	0	70,000.00
7,357.00	12,736.00	6,630.00	8,432.00	7,001.00	0	94,145.00
0	0	0	0	0	0	0
3,114.24	7,250.34	3,114.24	4,136.10	3,714.24	0	49,260.00
$167,858.98	$592,346.88	$311,745.08	$219,196.40	$295,740.38	$12,417.90	$3,354,611.20

Medical Board Gets Consent Decree From Nurse And HMO

By D. Brent Mulgrew, J.D., and Catherine C. Costello, J.D.,

The Ohio State Medical Association has entered a lawsuit filed by the Ohio State Medical Board. The Board believes the performance of a periodic gynecological examination — including a Pap smear, pelvic exam and breast exam — by a nurse is the unauthorized practice of medicine. Other parties to the lawsuit include: The Ohio State Medical Board, the Ohio Nursing Board and the Ohio Nurses Association. The following is a summary of the major developments in the case.

In December, 1982, the Ohio State Medical Board filed an enforcement action seeking an injunction against a Columbus HMO and its employee nurse. The injunction would prohibit the HMO and nurse from practicing medicine without a license by performing periodic gynecological exams. The Board alleged that the nurse was performing Pap smears, pelvic exams and breast exams as part of a routine gynecologic exam without the patient seeing a physician. In the particular case the nurse followed the exam by giving the patient a prescription for birth control pills, signed by a physician that the patient had not seen. The Medical Board action sought to prohibit the defendants from performing such acts and also a declaration by the judge that these actions constituted the illegal practice of medicine.

Last summer, the Ohio Nurses Association (ONA) intervened as defendants on the grounds that many of their members were currently performing the acts described and that these acts constituted the practice of nursing, not the practice of medicine.

Subsequent to the ONA entering the suit, the Ohio State Medical Association and the Ohio Board of Nursing Education and Nurse Registration moved to intervene. The Nursing Board attempted to refocus the issues in the case by stating that the defendants were not involved in the practice of medicine but rather were practicing professional nursing as defined in their practice statute. If this theory was accepted, the activities would be subject to the Nursing Board's review instead of the Medical Board. The Nursing Board argued to the court:

> "Although the plaintiff, State Medical Board, would undoubtedly claim that this action primarily involves whether certain acts constitute the illegal practice of medicine, the case more precisely involves determining whether the acts alleged were validly within the practice of professional nursing as defined in Revised Code Section 4723.06 . . . The Board of Nursing sets forth the defense that the alleged actions of the defendant do not constitute the illegal practice of medicine but rather are embraced within the practice of professional nursing." (pp. 2, 7 of Memorandum in Support of Motion to Intervene)

The Nursing Board further argued that if a nurse was taught in nursing school to perform these functions, then such activities are the practice of nursing, not medicine. Such an argument, if accepted, would mean that any individual who is taught to perform certain functions is qualified to do so, regardless of a state's licensure statutes.

A significant development occurred as the OSMA and the Nursing Board became parties to the suit. The Medical Board signed a consent decree with the HMO and the nurse which dismissed them as defendants. In the consent decree, the HMO agreed to the following restrictions:

". . . the Defendant (HMO) will not permit or cause, and will not permit or cause its employees and agents and all affiliated physicians, in the providing of health care services, the following described acts to be performed other than directly and

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The OSMA is registered as a 501 (c)(6) corporation with the Internal Revenue Service. To maintain such standing, the Association's activities must promote the common interest of the membership rather than provide specialized services to individuals. Consequently, this column will be devoted to general legal questions of interest to the membership. Suggestions for future columns may be sent to: OSMA Department of Legal Affairs.

personally by individuals who are duly licensed to practice medicine or surgery . . . unless permitted by rule of the State Medical Board or ultimately determined by a court of competent jurisdiction: (a) a pelvic examination performed in connection with the prescription of birth control medication; (b) a pelvic examination including the collection of specimen material for a papanicolaou laboratory examination performed in connection with a periodic gynecologic examination; (c) a breast examination performed in connection with the prescription of birth control medication or a periodic gynecologic evaluation; or (d) the initial prescribing and/or dispensing of birth control pills and the periodic writing and signing of refill prescriptions based on reexamination and reevaluation."

The employee nurse also agreed not to perform these acts in the future.

Notwithstanding the dismissal of the original defendants, the remaining parties have told the court they wish to go forward with the case to determine whether the actions described are the unauthorized practice of medicine. Technical and procedural issues must still be resolved but a tentative trial date has been set in March, 1984.

Regardless of the outcome of this case, the question of when an activity by a nurse is the practice of medicine will continue to be a major issue.

AMA House Endorses Independent Hospital-Medical Staff Counsel

At its interim meeting in December, 1983, the AMA House of Delegates approved a resolution introduced by the Ohio delegation. That resolution recommended that hospital-medical staffs retain independent legal counsel for their hospital activities when they have a different position than that of the hospital administration. This resolution changes an earlier position of the AMA that hospital-medical staffs should consult with but not retain separate counsel.

One of the reasons for this change is the aggressive position taken by some hospital lawyers who state that the medical staff does not have the right to consult with a lawyer independent of the hospital's counsel. The AMA House recognized that it is not essential to use a lawyer every time the hospital-medical staff and the administration disagree on an issue. In many situations, it is more appropriate for representatives of the administration and hospital-medical staff to attempt to resolve issues without lawyers. It is critical that lawyers not be used to settle personality problems, but rather independent counsel should be used when significant legal controversies develop between the administration and the medical staff.

The 1983 resolution stated that "the American Medical Association encourages medical staffs to consult with their own attorneys or those of their county medical society, state medical society, and/or the AMA in securing knowledgeable legal counsel as appropriate." The new AMA policy states: "The American Medical Association strongly recommends that hospital medical staffs retain their own attorneys so that the medical staff will have its own legal advocates to guide them."

During the next few months, the OSMA Department of Legal Services will be reviewing the utilization of independent counsel by hospital medical staffs in Ohio. Then we will prepare information for those staffs who may be considering retaining legal counsel.

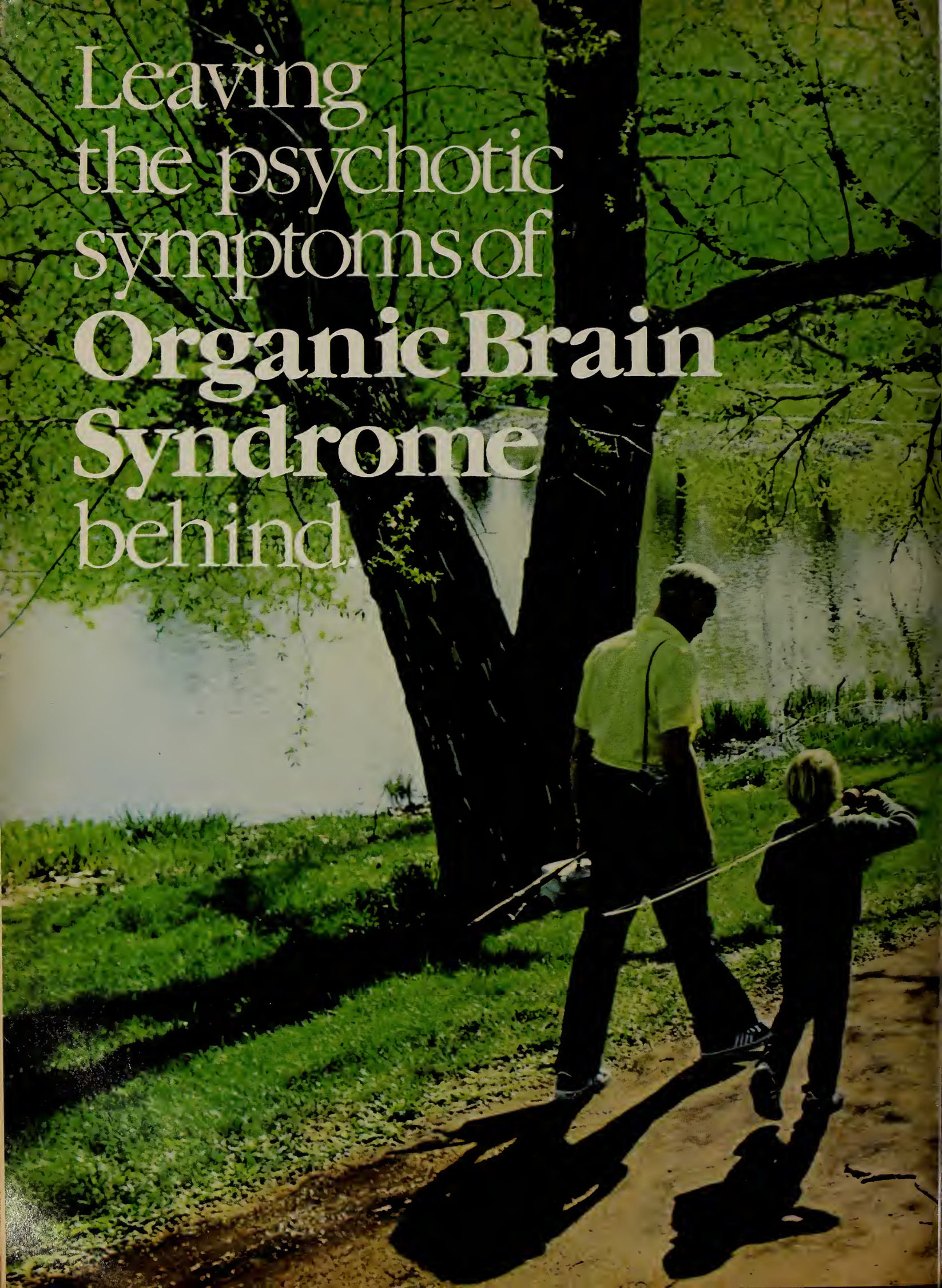
JCAH Litigation Dismissed

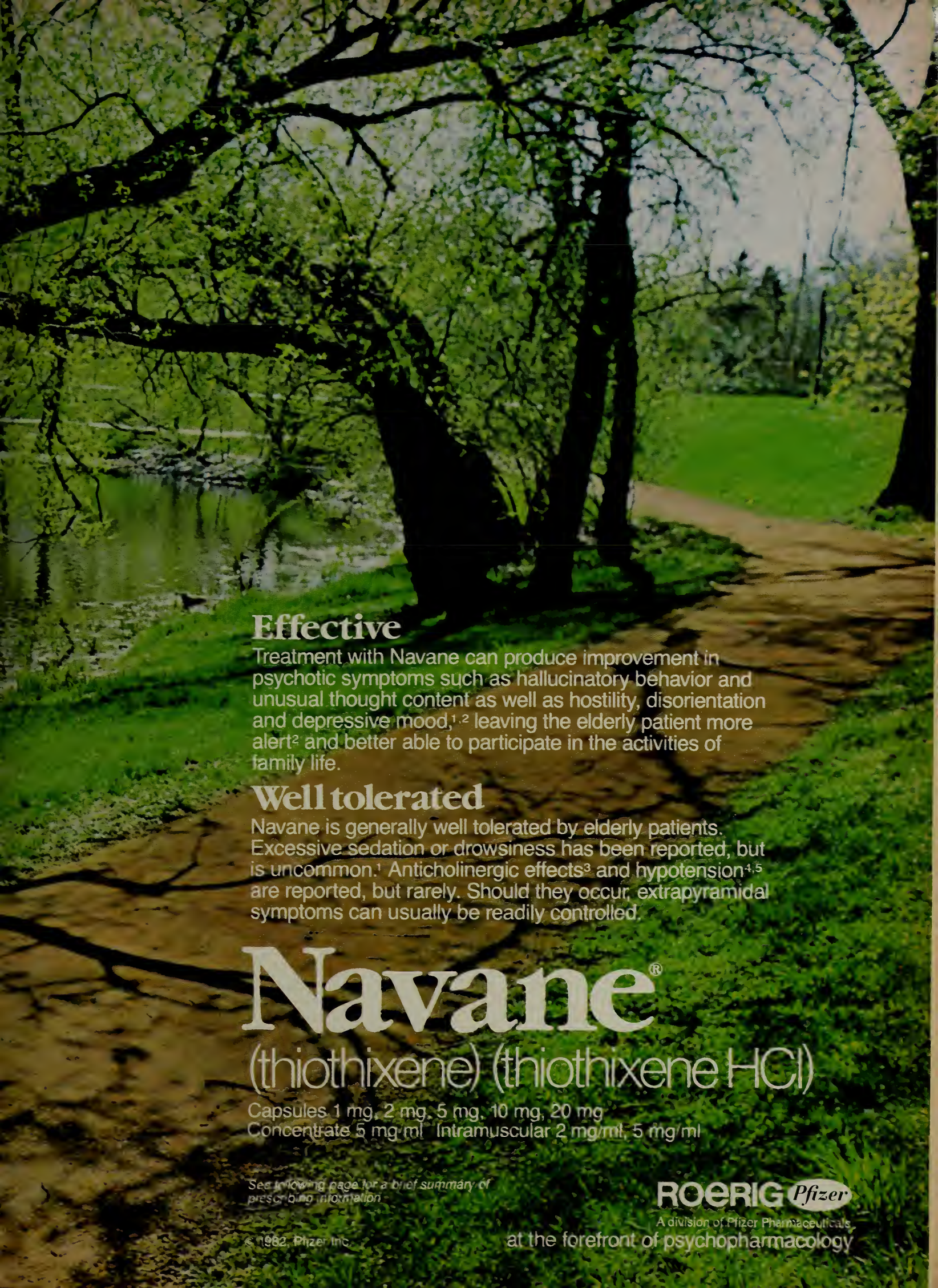
The Attorney General of Ohio, Anthony J. Celebrezze, Jr., recently dismissed the lawsuit, *The State of Ohio* vs. *The Joint Commission on Accreditation of Hospitals*, pending since 1979. The litigation was filed by the previous Attorney General alleging that the JCAH and others, (including the Ohio State Medical Association as an unnamed co-conspirator) were illegally restricting psychologists from admitting patients to Ohio hospitals. The dismissal stipulation recited, "Since the institution of this case, ORC Section 3727.06 has been enacted and the JCAH has passed new standards which moot any remaining issues of this action . . ." Sec. 3727.06 ORC is the new section in the hospital licensure bill that restricts admissions to hospitals to physicians, dentists and co-admission by podiatrists. The new statute was supported by the Ohio State Medical Association. The enactment of Sec. 3727.06 clearly defined those who could admit to hospitals and resolved any statutory doubt that psychologists were prohibited from independently admitting to Ohio's hospitals.

Appeals Court Refuses To Rehear AMA-Chiropractic Antitrust Suit

The AMA petition for a rehearing in the *Wilk* vs. *AMA* case was denied by the U.S. Court of Appeals in Chicago. The AMA Board of Trustees had decided in September to seek a rehearing after a two-judge panel reversed a 1981 jury verdict finding the AMA innocent of antitrust charges that had been brought by Chester A. Wilk and four other chiropractors. The original suit alleged that the AMA conspired with other medical groups to isolate and eliminate the chiropractic profession through ethical prohibitions. The appellate panel ruled that improper instructions had been given to the jury and ordered a new trial. The appellate court did not address the substance of whether the AMA and the other defendants were guilty of antitrust violations under the Sherman Act. The AMA request for rehearing argued that the instructions presented to the jury were proper and asked for a review of the antitrust

continued on page 129


Leaving
the psychotic
symptoms of
Organic Brain
Syndrome
behind.



Effective

Treatment with Navane can produce improvement in psychotic symptoms such as hallucinatory behavior and unusual thought content as well as hostility, disorientation and depressive mood,[1,2] leaving the elderly patient more alert[2] and better able to participate in the activities of family life.

Well tolerated

Navane is generally well tolerated by elderly patients. Excessive sedation or drowsiness has been reported, but is uncommon.[1] Anticholinergic effects[3] and hypotension[4,5] are reported, but rarely. Should they occur, extrapyramidal symptoms can usually be readily controlled.

Navane®

(thiothixene) (thiothixene HCl)

Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
Concentrate 5 mg/ml Intramuscular 2 mg/ml, 5 mg/ml

See following page for a brief summary of prescribing information.

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A division of Pfizer Pharmaceuticals
at the forefront of psychopharmacology

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Navane®
(thiothixene) (thiothixene HCl)

References: 1. Util TM, Unverdi C. Wohlrade J, et al: Drug therapy of psychosis associated with organic brain syndrome. Presented as a Scientific Exhibit at the American Public Health Association Centennial, Atlantic City, New Jersey, November 12-16, 1972. 2. Katz MM, Util TM: Video methodology for research in psychopathology and psychopharmacology. *Arch Gen Psychiatry* 31:204-210, 1974. 3. Ketai R: Psychotropic drugs in the management of psychiatric emergencies. *Postgraduate Medicine* 58:87-93, 1975. 4. Birkett DP, Hirschfield W, Simpson GM: Thiothixene in the treatment of diseases of the senium. *Curr Ther Res* 14:775-779, 1972. 5. Data on file at Roerig.

BRIEF SUMMARY OF PRESCRIBING INFORMATION
Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
(thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular: 2 mg/ml, 5 mg/ml
Contraindications: Navane (thiothixene) is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but the possibility should be considered.
Warnings: *Usage in Pregnancy*—Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration of Navane to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in Children—The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.

Precautions: An antiemetic effect was observed in animal studies with Navane, since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy, and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis) have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Neuroleptic drugs elevate prolactin levels; the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis; the available evidence is considered too limited to be conclusive at this time.

Intramuscular Administration—As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e. gluteus maximus) and the mid-lateral thigh.

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Adverse Reactions: *Note:* Not all of the following adverse reactions have been reported with Navane (thiothixene). However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used.

Cardiovascular effects: Tachycardia, hypotension, lightheadedness, and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines. The clinical significance of these changes is not known.

CNS effects: Drowsiness, usually mild, may occur although it usually subsides with continuation of Navane therapy. The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane (thiothixene). Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudo-parkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia: As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.



There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Undue exposure to sunlight should be avoided. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

Although not reported with Navane, evidence indicates there is a relationship between phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrome.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration.

Dosage and Administration: Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition. In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on once-a-day Navane therapy.

Usage in children under 12 years of age is not recommended because safe conditions for its use have not been established.

Navane Intramuscular Solution: Navane For Injection—Where more rapid control and treatment of acute behavior is desirable, the intramuscular form of Navane may be indicated. It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg/day. An oral form should supplant the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane (thiothixene) Capsules and Concentrate appear in the following paragraphs.

Navane Capsules: Navane Concentrate—In milder conditions, an initial dose of 2 mg three times daily. If indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg twice daily.

The usual optimal dose is 20 to 30 mg daily. If indicated, an increase to 60 mg/day total daily dose is often effective. Exceeding a total daily dose of 60 mg rarely increases the beneficial response.

Overdosage: Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, hypotension, disturbances of gait, or coma.

Treatment: Essentially is symptomatic and supportive. For Navane oral, early gastric lavage is helpful. For Navane oral and Intramuscular, keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors.)

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of the blood pressure.

If CNS depression is present and specific therapy is indicated, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Stimulants that may cause convulsions (e.g. picrotoxin or pentylenetetrazol) should be avoided. Extrapyramidal symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

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principles that the panel had applied in reaching its decision.

JCAH Hospital Medical Staff Standards Adopted

At its interim meeting, the AMA adopted a resolution stating that "The hospital medical staff may grant admitting privileges to appropriately credentialled limited-license practitioners in accordance with state law and in accordance with the criteria for standards of medical care established by the individual hospital medical staff."

The adoption of this resolution paved the way for the adoption of the final revisions in the medical staff chapter of the Accreditation Manual for Hospitals by the JCAH at its meeting December, 1983. An amendment, proposed by the AMA Commissioners to the JCAH, was adopted. The new medical staff standard reads as follows: "Individuals granted the privilege to admit patients to inpatient services are members of the medical staff. Individuals are granted the privilege to admit patients to inpatient service in accordance with state law and criteria for standards of medical care established by the individual medical staff. When non-physician members of the medical staff are granted privileges to admit such patients, provision is made for prompt medical evaluation by a qualified physician for all such patients. This requirement for prompt medical evaluation by a qualified physician does not apply to qualified oral surgeons who have been granted the clinical privileges to perform a history and physical examination. JCAH Board of Commissioners approved implementation of the new medical staff standards effective July 1, 1984 but with a delay in the impact on accreditation decisions until January 1, 1985. (Ed. note: Ohio state law limits hospital admitting privileges to medical and osteopathic physicians and surgeons, dentists, and co-admission by a podiatrist member of the staff with MD/DO physician member of the hospital's medical staff. Sec. 3727.06 ORC.)

Mrs. Carol E. Rolfes, Consumer Member of the Medical Board

This is the second article dealing with new Medical Board members. The January issue highlighted Deirdre O'Connor, M.D., physician member from Toledo.

Mrs. Carol E. Rolfes joined the Ohio State Medical Board in November, 1983, as a consumer member, replacing Mr. Walter Paulo. She brings a wealth of personal experience to the problems of the Medical Board. By training, she is a registered nurse, although illness forced her to retire from active nursing over a decade ago.

Mrs. Rolfes attended the University of Cincinnati and Xavier University, then received her RN degree from Good Samaritan School of Nursing. Her first position as a public health nurse in Cincinnati formed the basis of her interest in the health care problems of the indigent.

The Rolfes now reside in Cleveland. Between raising five children, Mrs. Rolfes became actively involved in the health care problems of the medically underserved in Cleveland. She helped organize two family health clinics in Cleveland and worked with the Cleveland Diocese Health Affairs Program. She remains active in many consumer groups, providing educational programs and helping them to understand the health care system.

As a consumer member of the Governor's Commission on Ohio Health Care Costs, Carol Rolfes has worked closely with Dr. David Jackson, the Director of the Ohio Department of Health. These activities have kept her abreast of the latest developments in health care cost containment.

In her role as Medical Board member, Mrs. Rolfes feels her primary duty is to act as spokesperson for Ohio consumers. As a priority, she would like to see the Medical Board become more involved in the problems of the impaired physician, and work closely with established groups such as OSMA's Impaired Physicians.

The Ohio State Medical Association welcomes Mrs. Rolfes to the Medical Board. **OSMA**

D. Brent Mulgrew, J.D., and Catherine Costello, J.D. are in OSMA's Department of Legal Services and serve as OSMA's Staff Counsel.

Synergy
You and your doctor working together to keep you healthy

Answering all of your patient's questions in the office takes up valuable time . . .

Let Synergy, the OSMA patient publication, help to answer your patient's general health and medical questions.

Provides: general health and medical knowledge

- **safety tips**
- **disease prevention**
- **seasonal health**

WRITE:
THE OHIO STATE MEDICAL ASSOCIATION
600 S. HIGH ST.
COLUMBUS, OHIO 43215

"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received not all patients will respond to Procardia nor will they all respond to the same degree.

© 1983, Pfizer Inc.

"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

* Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

Please see PROCARDIA *brief summary on adjoining page.*

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

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WILLIAM ALTEMEIER, MD, Cincinnati; University of Cincinnati College of Medicine, 1934; age 73; died November 23, 1983; member OSMA and AMA.

EDWARD G. DITCH, MD, Caldwell; University of Louisville School of Medicine, Louisville, Kentucky; age 82; died November 1, 1983; member OSMA and AMA.

ALEXANDER S. FISHER, MD, East Liverpool; Ohio State University College of Medicine, 1933; age 74; died November 23, 1983; member OSMA and AMA.

GASPARE GALATI, MD, Canton; Facolta di Medicina e Chiurgia dell Universita di Roma, Roma, Italy, 1955; age 58; died October 19, 1983; member OSMA and AMA.

FRANK R. HANRAHAN, MD, Cleveland; Case Western Reserve University School of Medicine, 1942; age 66; died November 23, 1983; member OSMA and AMA.

KU YIN LIN, MD, Cleveland; National Shanghai Medical College, Shanghai Kiangsu, China, 1938; age 69; died November 9, 1983; member OSMA and AMA.

HERBERT P. LYLE, MD, St. Petersburg, Florida; University of Cincinnati College of Medicine, 1934; age 73; died November 23, 1983; member OSMA and AMA.

ROBERT P. McFARLAND, MD, Oberlin; Case Western Reserve School of Medicine, 1962; age 56; died November 12, 1983; member OSMA and AMA.

LEONARD NIPPE, MD, Toledo; Northwestern University Medical School, Chicago, 1920; age 89; died November 22, 1983; member OSMA and AMA.

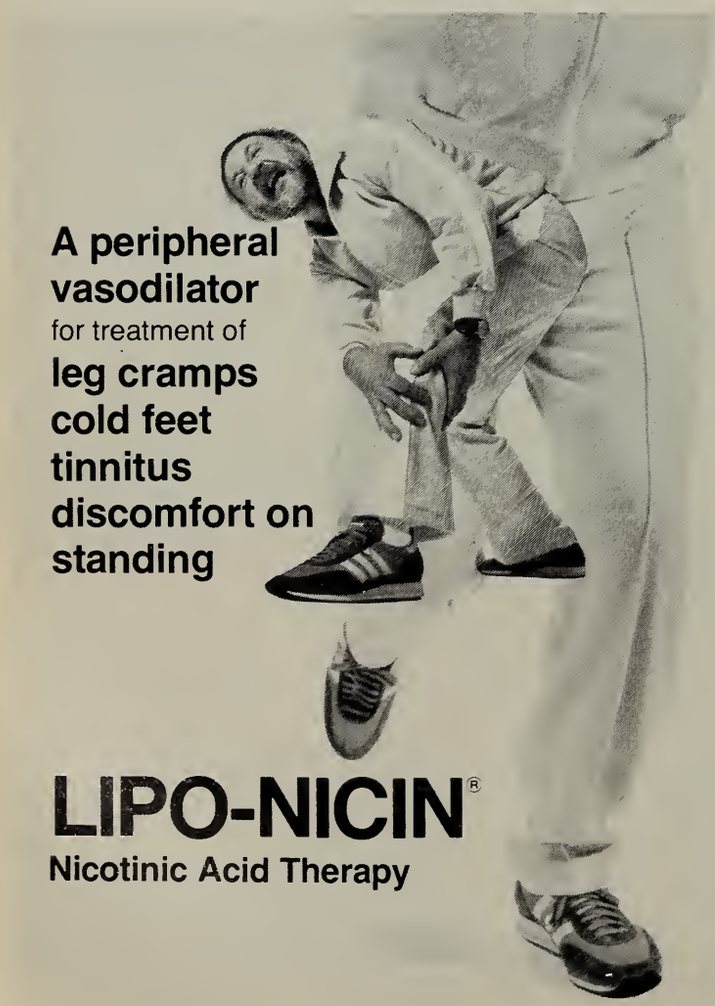
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CLINICAL CORNER

Edited by Larry C. Carey, MD

Editor's Note: This is the first "Clinical Corner" to be published in the *Ohio State Medical Journal*. It is the intent to have one such contribution per issue. The purpose of this effort is to provide concise, informative reviews of current topics of clinical interest. Contributions from the readership are welcome and should be sent to Larry C. Carey, MD, Department of Surgery, Ohio State University, N-747 Doan Hall, 410 West 10th Avenue, Columbus, OH 43210. The contributions should be limited to 4 to 6 typewritten pages and need not be illustrated. A brief, appropriate bibliography is welcome. It is the editors' hope that this will become a useful addition to the *Journal*.

— Larry C. Carey, MD

AIDS:

OHIO UPDATE AND COMMENTS ON DIAGNOSIS

By John C. Neff, MD

It is quite obvious to every Ohio physician that the AIDS (Acquired Immune Deficiency Syndrome) "revolution" is upon us. Termed by the media as a "raging epidemic" and the "public health threat of the century," it began to be recognized in late 1979 when the Centers for Disease Control alerted the medical community to a syndrome of severe opportunistic infection and Kaposi's sarcoma occurring in young male homosexuals in New York and California. During the past four years, the characteristics of this syndrome have been well documented, although its etiology remains obscure. It acts "infectious," viral, and appears to have a prolonged (6 months-2 years) incubation period.

I do not propose to tell you the most optimal way of making a diagnosis of AIDS. However I would like to make a few suggestions and to share with you our experience with the problem. Since early 1980, we have been asked to do immunological evaluations of some 90 patients who were "possible AIDS victims." As you well know, AIDS does not appear to be a major problem in Central Ohio at this time, and I can with reasonable confidence say that only a very small number of these 90 people actually have AIDS.

In determining AIDS, there appears to be no specific laboratory diagnosis, and it is our opinion that the primary diagnosis must be principally clinical, with laboratory support.

As of early September, 1983, a total of 2,259 cases of AIDS meeting the strict CDC criteria had been reported. Ninety percent of patients with AIDS can be placed in definite epidemiological groups, that may suggest possible mechanisms of acquisition: 70% are men with homosexual or bisexual orientations, 17% have used IV drugs (this group includes 50% of the women, and most of the rest of the females, 150 cases in total, cohabitated with males who had strong risk factors), and 1% were hemophiliacs. Of the remaining 11%, 5% are Haitians, 1% were heterosexual partners of AIDS patients, 1% appear to have been exposed by blood transfusion, and 4% are either incompletely studied or belong to none of the above groups.

Please note that of this total of

continued on next page

2,259 cases, only 15 (.006%) have been reported in Ohio. This is clearly a "big city" disease, with 65% of the cases being accounted for by New York City, San Francisco, Los Angeles and Miami; 42% have been reported in New York City alone.

I would now like to make a few comments about the diagnosis of this disease. We should bear in mind, however, that as of this time, AIDS is a low prevalence disease in Ohio; therefore most of the cases we think we have found will be in fact false positives. We are not absolved from looking, but with great caution, the same caution we would have about making a diagnosis of true plague (Yersinia pestis) here in Ohio. I would like to emphasize as strongly as possible that the diagnosis of AIDS should be *clinical*, with appropriate *laboratory confirmation.* The Centers for Disease Control defines a case of AIDS as "disease, at least moderately predicative of a defect in cell mediated immunity, occurring in a person with no known cause of diminished resistance to that disease." Such diseases include Kaposi's sarcoma, Pneumocystis carinii pneumonia, and other "opportunistic" infections such as pneumonia, meningitis, or encephalitis due to one or more of the following: Aspergillus, Candida, Cryptococcus, Cytomegalovirus, Nocardia, Strongyloides, Toxoplasma, Zygomyces, or atypical mycobacteria; esophagitis due to Candida, Cytomegalovirus, or Herpes simplex virus; progressive multifocal leukoencephalopathy; chronic enterocolitis due to cryptosporidiosis; or unusually extensive mucocutaneous Herpes simplex of more than five weeks duration. This method of case definition is purposefully specific, and excludes patients with prior immunosuppressive therapy, lymphoproliferative malignancy, or other predisposing factors. If these "tight" criteria are not applied, my sense is that the diagnosis of AIDS may be entertained, and in fact, made more frequently than is justified.

We have been asked what constitutes an adequate laboratory diagnosis of AIDS. There appears to be no specific laboratory diagnosis, and it is our opinion that the primary diagnosis must be principally *clinical*, with laboratory support. The "at risk" population, as well as their presenting malignancies and opportunistic infections, have been well summarized. Given the appropriate clinical situation, we suggest that the following clinical and laboratory tests to support the diagnosis of AIDS be done.

1. Biopsy of suspicious cutaneous lesions; biopsy of enlarged lymph nodes
2. Laboratory assessment:
   CBC, absolute lymphocyte count
   T-cell/B-cell partition, T-helper/T-suppressor ratio
   Serum protein electrophoresis, immunoglobulin quantitation (G,A,M)
   Infectious disease antigen antibody assays, specifically HBs, anti-HBs, anti-Hbc, EBV, CMV, Herpes
3. Appropriate cultures and biopsies to document offending pathogen.

It is important to again emphasize that if AIDS is indeed an infectious disease, it does not appear to be highly contagious.

There are many other determinations that you may wish to consider, such as skin testing for recall antigens (PPD, Histo, Candida), lymphocyte blast transformation studies against mitogens, recall antigens, complement profiles, natural killer cell assays, etc. Please note the attached table of assays which we have recommended, and the expected abnormality in typical AIDS cases (Table I). To those of you who are not used to ordering immunological evaluations, this may seem to be a great deal of laboratory work. I cannot emphasize enough that this would appear to be the irreducible minimum required. Certainly simply determining the T-cell subset ratio is not sufficient. Many diseases which are not serious (routine CMV, EBV, measles, etc.) and drugs at therapeutic levels may "flip" this ratio. It is the picture of T-cell cellular immunodeficiency, with a marked reduction in T-helper numbers, accompanied by a B cell hyper-responsiveness that is one of the key laboratory features of this syndrome.

It can be said that, short of the finding of an opportunistic infection, Kaposi's sarcoma, etc., and supporting laboratory data in a patient known to be at risk for the development of AIDS, there can be no sure diagnosis of the syndrome. As noted above, the lack of a specific "marker" for the disease causes some difficult problems. Three are particularly difficult:

1. The occurrence of a "Lymphodenopathy — Wasting Syndrome" in those at risk, but who do not as yet have "AIDS." For as long as one to two years before they develop their first serious opportunistic infection some AIDS victims may have recurrent fevers, weight loss and general "failure to thrive." Not everyone with this symptom complex develops the syndrome, however.
2. At risk people who are sick from other diseases, but who have laboratory values that are "AIDS-like." A number of common infectious diseases (measles, infectious mononucleosis, CMV, hepatitis, etc.) are *normally* associated with inverted T-cell subset values, which may persist for months.
3. People who are not at risk, but who have "AIDS-like" laboratory values.
4. Hemophiliacs, particularly those severe enough to have required large amounts of AHF concentrate. AHF is derived from the plasma of 2,000-5,000 donors, in contrast to cryoprecypitate, which is prepared from the plasma of individual donors. The former preparation however is the only practical form that can be used for ambulatory care programs, and has allowed severe hemophiliacs to lead near

normal lives since its introduction in the late 1960s.

Given the wide press coverage of this disease, AIDS is likely to be high on the differential diagnosis list for any young male who is febrile, has unexplained adenopathy, etc. Caution must be employed in interpreting the test results from such patients, even when they are abnormal. Every single AIDS "abnormal" value "flipped" T-cells ratio, polyclonal gammopathy, positive anti-HB, etc. — may be seen in patients who are either normal or have a wide variety of diseases or drug associated reactions. What are we then to say about the patient who has generalized lymphadenopathy, periodic fevers, some weight loss, some suggestive laboratory data and a social history that "might" put them at risk for the development of AIDS? The same might be asked for a patient with hemophilia who has had significant amounts of Factor VIII concentrate over the past several years, and has several laboratory values that have been seen in clear-cut AIDS patients. Are they "pre-AIDS," or merely showing the result of chronic nonspecific antigenic stimulation, or some viral disease as yet diagnosed, a drug effect not yet realized, or any of a host of other conditions. Certainly these patients, particularly if they have the appropriate social or therapeutic history, must be closely followed with appropriate laboratory and clinical observations. However we proceed, it is my impression that we should not abandon accepted diagnostic practice. Common things are still common, and AIDS does not appear to be very common, as yet, in Central Ohio. If node biopsy would have been the accepted practice in a given patient in the past, it should be now. If that means repeated node biopsy over the course of a year, then so be it. Suspicious skin lesions should be biopsied, and appropriate cultures taken. Certainly much more specific sexual, travel and drug use histories are now mandatory. At this point, however, it appears that only time will tell whether the above noted patients in fact have AIDS.

Lastly a few comments concerning possible etiologies, and a few public health considerations. We do not know what "causes" AIDS, but at least four major considerations are currently popular.

1. Repeated infections with known viruses such as the Epstein-Barr virus and cytomegalovirus have been considered. Certainly high antibody titers to both viruses are found in the serum of AIDS patients. More recently, the human T-cell leukemia virus (HTLV) has been suggested as a more probable suspect. Perhaps the infection must occur in patients with certain genetic makeups; approximately 50% of male homosexual AIDS patients with Kaposi's sarcoma are HLA-DR5 positive, as compared with 20% of the normal population. It should be recalled that many viruses such as CMV, measles, etc. are temporarily immunosuppressive in normal people.
2. Some illicit drugs, such as amyl nitrite, which many of the early AIDS cases were found to use as a recreational drug, are known to produce immunosuppression. Too many cases have not had such a history, however, for serious consideration of this hypothesis.
3. For some time it has been known that there are proteins in human semen which are immunosuppressive. Large amounts of semen may be deposited in the gastrointestinal tract of male homosexuals over the period of several years, and direct contact between semen and blood vessels may occur at mucosal trauma sites.
4. AIDS may be caused by an infectious agent, the nature of which is unknown to us. Currently, the sum total of epidemiological evidence would appear to favor a viral type agent, which is not highly infectious, and which has a very long incubation period.

It is important to again emphasize that if AIDS is indeed an infectious disease, it does not appear to be highly contagious. In addition, the evidence that AIDS can be transmitted through blood components remains incomplete. Less than 10 cases with

continued on next page

TABLE

TEST	REFERENCE RANGE	EXPECTED FINDING, CONFIRMED AIDS CASE
Serum Protein Electrophoresis	Normal distribution five electrophoretic fractions	Polyclonal Gammopathy, principally IgG, IgA acute phase reactants often present
Serum Immuno-globulins	IgG-900-1200 mg/dl IgA-100-300 mg/dl IgM-90-120 mg/dl	IgG, IgA often markedly elevated, IgG in Kaposi's/ IgA in opportunistic infection
Lymphocyte Count	1000-3000/mm^3	Lymphopenia
T/B Partition	T: 81%-92% B:3%-11%	Often normal
T-Cell Sub-Set Ratio	1-2	Low, "flipped"
EBV CMV Herpes	Varies with age	Often positive, very high, do not decrease with time
Anti-HB_c	Varies, usually under 5% of population positive	Very often positive, 90%

possible linkage to transfusion has been encountered to date, despite 10 million or more transfusions annually. There is no basis for unwarranted concern about giving Red Cross blood or blood products to our patients, particularly in Ohio. Finally, the classification of certain population groups as being more closely associated with the disease has been interpreted by some to mean that these groups are likely to transmit the disease through non-intimate interactions. Such is not the case; this disease appears to be transmitted in a manner similar to Hepatitis B, that is sexually or parenterally. The view that this disease can be transmitted through non-intimate interactions is simply not justified.

Until we can more specifically diagnose this disorder, and hopefully one day treat it, we must place AIDS in its proper perspective, move to calm unrealistic fears of many of our patients and approach this disease as rational physicians. **OSMA**

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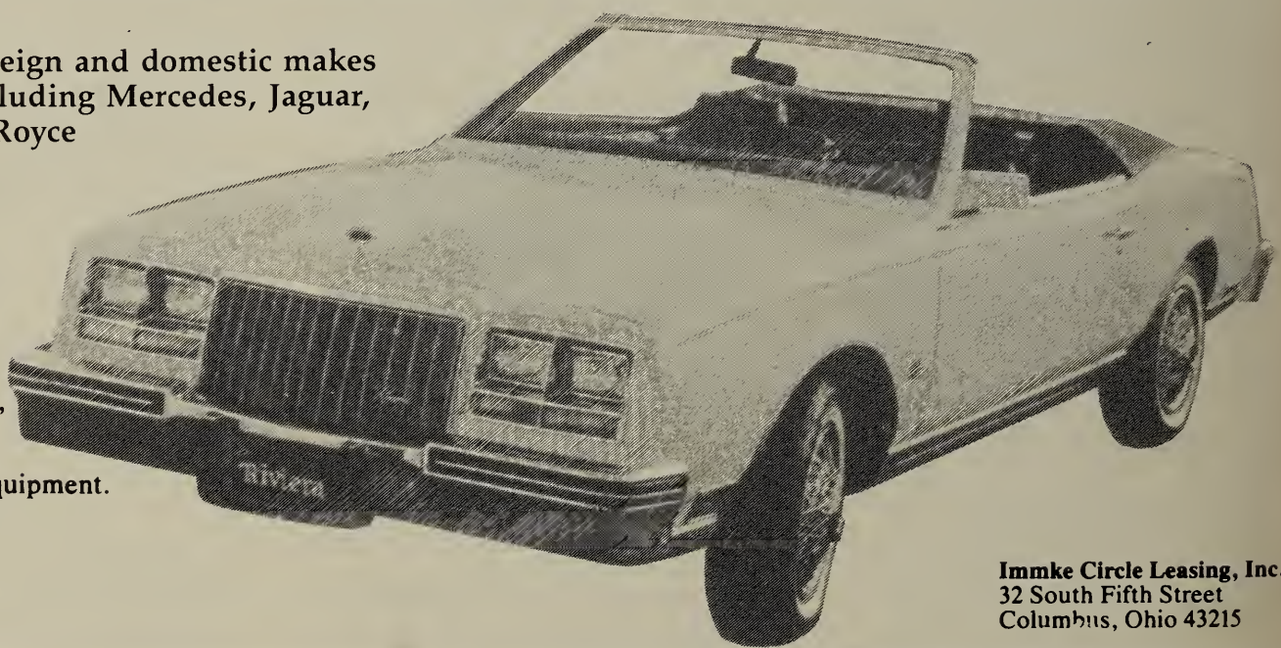
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CLINICAL NOTES

Edited by Karen S. Edwards

Medical Self-Care Can Reduce Costs

Total office visits and visits for minor illnesses were reduced 17% and 35% respectively among families in a health maintenance organization (HMO) who participated in an educational program encouraging medical self-care, writes Donald M. Vickery, MD, from Georgetown University School of Medicine. The families received some combination of services that included individual counseling, a telephone information service and written materials that focused on lifestyle changes and care for common medical problems.

— *Journal of the American Medical Association*
December 2, 1983

Preoperative Chest X-Rays Questioned

Preoperative chest x-rays are "useless" as a screening procedure for abnormalities in patients without identified risk factors for chest disease, according to Lloyd Rucker, MD, and colleagues from the University of California, Irvine, Medical Center. Findings from their review of 905 patient charts revealed an abnormal x-ray in only one patient (0.3 percent) of the 368 who had no listed risk factor. About $25,000 could have been saved by eliminating preoperative chest x-rays in the no-risk patient group, Rucker says.

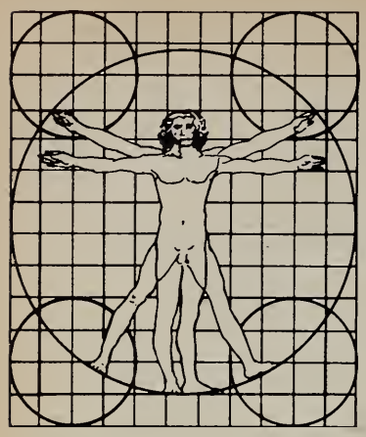
— *Journal of the American Medical Association*
December 16, 1983

Food-Exercise Allergy

The wrong combination of food and exercise can induce a severe allergic reaction in sensitive individuals, reports Ellen M. Buchbinder, MD, and colleagues at Harvard Medical School, Boston. They describe the case of a 24-year-old woman who experienced symptoms of systemic anaphylaxis following jogging after eating a peach or grapes. She was able to run without incident if she fasted for two hours before exercise. "Food-dependent, exercise-induced anaphylaxis has been reported in relation to ingestions of celery, shellfish, fruit and a variety of solid foods," the authors say.

— *Journal of the American Medical Association*
December 2, 1983





CLINICAL & SCIENTIFIC

THE VALUE OF SCREENING UMBILICAL CORD BLOOD FOR HEMOGLOBINOPATHY

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Neonatal detection of hemoglobinopathy by electrophoresis of umbilical cord blood reduces mortality in sickle cell disease, when followed by consistent medical attention. Cord blood screening in Cincinnati since 1974 has detected 62 infants with major hemoglobinopathy, including conditions involving hemoglobins S, C, D, and E; and alpha and beta thalassemia. There has been only one death among these infants continually followed here, and a remarkable reduction in the case fatality rate of bacterial septicemia has been observed. Additionally, 9% of black infants screened have had Hg S or C trait and 90% of their mothers have received counseling.

Systematic screening of umbilical cord blood by electrophoretic techniques for hemoglobin abnormalities has been performed since 1961,[1], and clinical and research applications of this technique have expanded over the last decade.[2-16] The primary objective of cord blood screening is the identification of infants at clinical risk with sickle cell disease. Other goals include the formulation of patient cohorts for prospective studies of sickle cell disease, the identification of infants with other types of clinically significant hemoglobinopathy, and the detection of heterozygous carriers followed by the screening and counseling of family members.

This paper examines further the rationale for hemoglobinopathy screening at birth. The results of the Cord Blood Screening Program of the Cincinnati Comprehensive Sickle Cell Center are presented to demonstrate the beneficial effects such screening has achieved.

The Early Morbidity And Mortality of Sickle Cell Disease

The significance of diagnosing major sickle hemoglobinopathies at birth is made clear by noting the significant morbidity and mortality of the disease in infancy and early childhood. Hemolytic anemia is apparent at a mean age of 8-10 weeks in children with hemoglobin (Hg) SS, and symptomatology often begins as early as about 3 months.[2,3] In the first year of life, potential manifestations include painful dactylitis or other types of vaso-occlusive crises, major infections and splenic sequestration.[4-7,17] Splenic reticuloendothelial hypofunction is apparent in half of children with Hg SS by 1 year of age and in almost all by 2 years of age.[2,18] The risk of septicemia and/or meningitis is approximately 10% in children with hemoglobin SS, with approximately 2/3 of the cases occuring before 2 years of age in most series.[17,19] During the first decade of life, the peak of morbidity and the modal age of death is 2-3 years.[17]

The presenting symptoms of these complications are usually nonspecific and are often falsely innocuous appearing, making prior diagnosis of the hemoglobinopathy extremely valuable. For instance, painful crisis in a young child frequently will be manifest with only subjective pain and irritability and without objective signs. Data from our institution clearly show that children with sickle cell disease may have life threatening septicemia yet present with prodromal symptoms not indicative of serious illness, unimpressive temperature elevations, and very benign physical examinations.[19]

Many clinicians are well aware of sudden death occasionally being the first major manifestation of sickle cell disease and the episode that leads to definitive diagnosis of the hemoglobinopathy. In a 10 year period in Los Angeles, seven black children under 5 years of age, previously not suspected to have any illness, were demonstrated to have Hg SS and pneumococcal septicemia by postmortem studies following sudden death.[17] Death has been the presenting manifestation of previously undiagnosed sickle cell disease in at least three children in the Cincinnati area in the last 3½ years.

The Beneficial Effect of Neonatal Diagnosis of Major Hemoglobinopathy

The diagnosis of a major sickle hemoglobinopathy at birth allows many types of intervention which might be expected to lessen this morbidity and mortality. Foremost

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Submitted August 2, 1982

among these interventions are parental education about the disease and immediate entry of affected infants into a health care system. Parents can react much more quickly to significant signs and symptoms, and health personnel can make appropriate diagnoses and treatment plans more quickly. Psychosocial supportive services can be implemented before adverse effects of a complex chronic illness become advanced.

Is there evidence that these types of interventions do make a difference? In two early studies of infants whose hemoglobinopathies were diagnosed at birth, but to whom emergency medical care was not readily available, 30% still died in the first two years of life.[1,4,5] On the other hand, in reports describing infants diagnosed at birth and immediately entered into a comprehensive system of medical care, mortality was notably reduced.[6,8,20] The greatest effect was a decrease in the previous case fatality rate of 10%-40% for pneumococcal septicemia, historically the major cause of death in children with sickle cell disease. In two of these series, all patients who developed pneumococcal septicemia survived.[6,20]

There is less solid data on morbidity. Our impression, shared by others caring for children with sickle cell disease, is that disease morbidity has been reduced. For instance, we see less often severe splenic sequestration, and this is probably because of the early institution of hospitalization, intravenous fluids and antibiotics for fever. The reduction in mortality from sepsis is almost surely associated with an as yet undocumented decrease in the morbidity among survivors as well, related to earlier therapy of, or prevention of, central nervous system infection. Prospective studies of patients diagnosed at birth have identified risk factors such as early onset of splenomegaly or dactylitis, early elevation of the red cell pit count, and a low percentage of fetal hemoglobin which often have predictive value for future disease severity.[5,7,9,10] Thus physicians may now observe more closely and intervene more quickly in a subset of patients at greatest risk. There also seems to be a reduction in psychosocial stress and better emotional adaptation to life-long effects of chronic illness in those families who have had the earliest intervention.

The Cord Blood Screening Program of the Cincinnati Comprehensive Sickle Cell Center

Data from the Cincinnati Comprehensive Sickle Cell Center of Children's Hospital Medical Center illustrate many of the above points. Cord blood screening started in 1974 for all infants born at Cincinnati General Hospital and was expanded in 1980 to include all infants born at Bethesda Hospital. Specimens are transported to the Electrophoresis Lab of Children's Hospital and are evaluated by hemoglobin electrophoresis on cellulose acetate at alkaline pH and on citrate agar acid pH. This technique is in widest current use; having proven relatively sensitive, specific, rapid, and inexpensive.[11,15,21]

Over 29,000 newborns have been screened, of which 60%-65% have been black, the population at greatest risk for sickle hemoglobinopathy. Through the two participating hospitals, we are currently screening 80% of the black infants born in the greater Cincinnati area. A major hemoglobinopathy has been detected in 62 infants, representing about 1 in 300 of the black infants screened. Only one test falsely negative and one test falsely positive for clinically significant hemoglobinopathy have been identified. An infant initially diagnosed as having HgS trait was proven to have HgS-beta+ thalassemia, and an infant initially diagnosed as having Hg CC disease was proven to have Hg C trait. The final diagnoses of the 62 infants with major hemoglobinopathy, confirmed after appropriate follow-up and family studies, are listed in Table 1.

All these children have been followed in the Sickle Cell Clinic of Children's Hospital except a Cambodian infant with Hg EE who is followed in the Hematology Clinic. The oldest child followed is now 8½ years old. Over 70% of all the children followed in the Sickle Cell Clinic under 8 years of age were detected by cord blood screening. All of these children diagnosed at birth have remained as active patients in the Sickle Cell Clinic except four. Of these four, only one left our care because the parent chose to have care elsewhere in the local area. Two other children have moved from the city, one of which died within months after moving. The fourth child no longer followed was a 4-year-old boy with Hg SC disease who died of acute massive splenic sequestration occurring with a brief febrile illness of presumed viral etiology. Pre and postmortem blood cultures were negative. He represents the only fatality among infants diagnosed at birth and continually followed in our Sickle Cell Clinic.

As mentioned above for other institutions, a decrease in mortality from septicemia and meningitis has been demonstrated in our patients. Over the last 10 years, in sickle cell patients seen here but *not* diagnosed by cord blood screening, there have been six fatalities among 20 episodes of septicemia (13 with *S. pneumoniae*, including all the fatal cases; 7 with other organisms). In contrast, while the incidence of septicemia has been similar, there have been no deaths and no late sequelae from 10 episodes of bacterial septicemia and/or meningitis (6 with *S. pneumoniae*, 4 with other organisms) occurring in children from the cord blood program. This difference in the case fatality rate approaches statistical significance for total septicemic episodes ($p = .06$) and for pneumococcal infections specifically ($p = .06$)*.

TABLE 1
Major Hemoglobinopathies Diagnosed from Umbilical Cord Blood, 1974-Present

Hemoglobinopathy	Number of Infants
SS	28
SC	19
S−β^+ thalassemia	4
S−β° thalassemia	1
S−§β thalassemia	1
SS−α thalassemia	1
SD$^{\text{Los Angeles}}$	1
S-hereditary persistence of fetal hemoglobin	1
CC	4
C−β^+ thalassemia	1
EE	1

The age range of these infected children from the cord blood screening program was 8 months to 5½ years (median age, 18 months). Many of them presented looking only mildly ill, without signs of a major systemic infection, and for some this was the first symptomatology related to their sickle cell disease. On numerous occasions, mothers of these septicemic children related to us that their rapidity of response to fever was motivated by their earlier education about sickle cell disease. If their hemoglobinopathy had not

previously been recognized, many of these children clearly would not have had the rapid evaluation and institution of parenteral antibiotics that they received.

The Neonatal Diagnosis of a Hemoglobinopathy Trait

In addition to newborns with clinically significant hemoglobinopathy, cord blood electrophoresis also detects a much larger number of infants with the heterozygous carrier state, or trait, for hemoglobinopathy. The carrier state for Hg S, C, or other less common abnormalities has been diagnosed in 9% of the black infants we have screened. There are several schools of thought as to what should be done with trait results. Some advocate a report which indicates the presence or absence of sickle cell *disease*, in which case the carrier state is reported as a negative result. More frequently, a specific genotype is specified and the results placed in the medical record and/or referred to the primary care physician of the child. We, and some others, feel that the parents have a moral and ethical right to information about tests carried out on their child. Therefore, we inform all parents of infants with a hemoglobinopathy trait, usually before the mother leaves the hospital, and offer further counseling and education.

It is important that an effective follow-up exists as a part of cord blood screening, not only for infants with disease, but also for those with hemoglobinopathy traits. Myths and misinformation must be eliminated by effective education. It was very common, and unfortunately is still not rare, for persons to feel that sickle cell trait is a mild form of the disease, that it will progress, or that it is contagious. Presentation of results without adequate information and the availability of further testing of family members is undesirable and unsatisfactory. We counsel in depth over 90% of the mothers of infants found with Hg S or C trait.

The Neonatal Diagnosis of Alpha Thalassemia

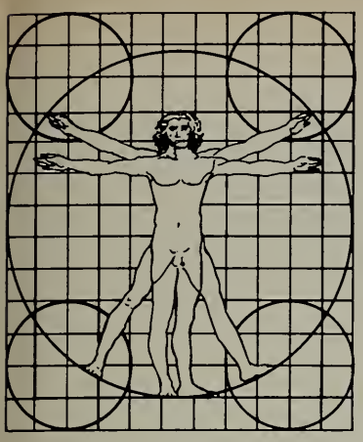
Although beta thalassemia minor is indistinguishable from normal by cord blood electrophoresis, the diagnosis of a clinically significant alpha thalassemia syndrome is suggested by the presence of greater than 2% Hg Bart's. Resulting from an imbalance in globin chain synthesis related to decreased alpha chain production, Hg Bart's consists of a tetramer of gamma globin chains, the predominant non-alpha globin chain present at birth. Currently, information on the presence of Hg Bart's is referred to the primary care physician of the affected child, and aids in the differential diagnosis of hypochromic anemia, often preventing inappropriate iron therapy for a microcytic, hypochromic anemia noted later in infancy.

Summary

The rationale for screening umbilical cord blood for hemoglobinopathy is discussed and the beneficial effects are documented. Foremost among these is the optimized quality of care that can follow the immediate involvement of an infant with sickle cell disease and its family in an appropriate health care system. This is exemplified by the reduction in the case fatality rate of pneumococcal septicemia that has been achieved. Appropriate follow-up of screening also includes transmission of information about the diagnosis of a hemoglobinopathy trait or alpha thalassemia to affected families and their physicians, with ready availability of education and counseling.

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CLINICAL & SCIENTIFIC

KAPOSI'S SARCOMA — AN ACQUIRED IMMUNODEFICIENCY SYNDROME

Joy A. Price, PhD
James H. Price, PhD, MPH

Acquired Immunodeficiency Syndrome (AIDS) has become a major health concern, following the pattern of an infectious agent with a high risk of fatality. One of the frequent sequellae to AIDS has been Kaposi's sarcoma, a rare but familiar neoplasm. This review of Kaposi's sarcoma re-examines the questions concerning the associations between viral infections, immunodeficiency and the carcinogenic process.

WITHIN THE PAST two and one-half years, an unusual syndrome has developed among American male homosexuals. The acronym "AIDS" has been coined for the syndrome and refers to "acquired immunodeficiency syndrome." The symptoms include persistent fever, weight loss, general malaise, general lymphadenopathy, and splenomegaly.[1] It is a serious public health problem because about one-third of the patients contract a rare form of cancer called Kaposi's sarcoma.[2]

Kaposi's sarcoma was first described by Moricz Kaposi, a Hungarian physician, in 1872.[3] It is a neoplasm of multifocal origin which presents as multiple vascular nodules of the skin and other organs.[4] Classically, the disease is presented as a localized nodular tumor, ranging in color from blue to purple on a lower extremity.[5] In North America and Western Europe, Kaposi's sarcoma was relatively rare, with an incidence of two to six cases per 10,000,000 persons.[5]

The disease is more common in Equatorial Africa, Italian populations and Ashkenasi Jews. In Equatorial Africa, it accounts for 9% of all malignancies, but the characteristics and course of the disease differ from the classic form.[6,7] This form of the disease is more disseminated anatomically and frequently has visceral and lymph node involvement.

The geographical distribution of Kaposi's sarcoma among the people of Equatorial Africa is reminiscent of African Burkitt's lymphoma.[6] The African form of Kaposi's sarcoma is more aggressive and usually develops in children and young adults, whereas the traditional rare form occurs more often in older men. The ratio of men to women who contract the disease is 10-15:1 (rare cases of Kaposi's do develop in women).[8] The death rate from the more aggressive form is much higher than the classic disease which had a survival rate of eight to 13 years.[8] In Africa, young persons who had the severe form usually all died within three years.[9]

It is this drastic form of Kaposi's which has appeared in American male homosexuals (particularly those in New York City and California).[10] They are also, for the most part, dying rather quickly. Most of the homosexuals with Kaposi's have lived in large cities, used drugs, and had a history of repeated microbial infections.[11]

Acquired Immunodeficiency Syndrome

The other major manner in which the AIDS syndrome presents itself, besides Kaposi's sarcoma, is through severe infections by any number of pathogens: viruses include cytomegalovirus and herpes simplex; among bacteria, *Mycobacterium tuberculosis, M. aviumintracellulare, Klebsiella pneumoniae* and other gram-negative aerobic bacilli; among fungi, *Candida albicans* and *Cryptococcus neoformous;* and among protozoa, *Pneumocystis carinii, Toxoplasma gondii* and *Entamoeba histolytica.*[11] The causes of death in patients with AIDS may include toxoplasmosis, viremia and bacterial sepsis.[12] Three hundred new cases of the syndrome have been reported since 1979 with 86% of them since January 1981.[12]

Although the incidence of AIDS in male homosexuals has reached epidemic proportions only in the United States, it has recently been reported in European homosexual men who have had sexual contact with homosexuals in the United States.[1] On the average, two to three cases of this syndrome are being identified every day.[2]

The fact the syndrome is spreading so rapidly within a specific subpopulation and that it can develop into an extremely fatal neoplasia makes it a promising candidate to gain some understanding of carcinogenesis. Although there are a number of characteristics shared by the homosexuals who develop Kaposi's sarcoma, no specific etiology has been identified. A possible cause of the acquired immunodeficiency may be hyperinfection by sexually transmitted viruses such as cytomegalovirus (CMV), which has been shown to depress immune function.[13]

Many of the homosexuals with AIDS have also used the sexual stimulant amyl nitrite, which also acts as an immunosuppressant. Exposure to sperm from many sources may also contribute to AIDS in homosexual men, since sperm are immunosuppressive if allowed to enter the blood stream.[2] Sperm can enter the blood stream via lesions in the mucous membrane of

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the anorectal region.

This immune deficiency seen in homosexual men is characterized by a selected reduction of helper/inducer T lymphocyte cells and a possible activation of the suppressor/cytotoxic population of cells.[14] The T cell population of helper/inducer cells includes those involved with hypersensitivity, antibody production and related effector function.[14] Helper/inducer T cells aid other immune cells to perform their function, whereas suppressor/cytotoxic T cells inhibit immune cells. Thus, loss of helper function with the amount of suppressor cells remaining constant, or possibly activated, compounds the immunosuppression.

Besides lowered amounts of helper T cells, persons with acquired immunodeficiency may also have a reduction in another immune cell, the natural killer, which is thought to be involved in cancer cell surveillance.[2] In other words, the cell-mediated immune system appears to be damaged in this homosexual population. However, many patients have elevated levels of the serum immunoglobins, IgG, and in some cases, IgA.[5,12] This high antibody titre is produced by the intact humoral immune system which is responding to the opportunistic infections which take advantage of the defective cell-mediated immunity. The B cell population within the immune system is relatively unaffected in these individuals.[14]

This defect in the host's surveillance system leads to increased infections (the most common being *Pneumocystis carinii*), as well as greater susceptibility to viral pathogens, such as Epstein-Barr virus, cytomegalovirus, and herpesvirus.[6] These viruses have been shown to have cell transformation capabilities, and thus may potentiate oncogenesis in immunosuppressed individuals.[6]

Etiology

The question becomes whether the immunodeficiency is the cause of the increased viral infections, or whether the viral infections cause the immunodeficiency. The fact that Kaposi's sarcoma is being seen in renal transplant patients and patients chronically treated with immunosuppressives supports the notion immunosuppression may be the etiology.[11,12]

On the other hand, Kaposi's sarcoma is also being seen more frequently among drug addicts and in hemophiliacs.[2] Since drug addicts often use unsterile needles, which allow for easier transmission of infections, and hemophiliacs are exposed to high concentrations of blood-borne pathogens, there is the implication that Kaposi's may be spread via a viral or viral-like mechanism.

Another unique population with an apparent increase in incidence of Kaposi's sarcoma is the Haitian immigrants who recently came to the United States. Currently, no one knows of an association with these Haitians and outbreaks of the disease in homosexuals, drug addicts or hemophiliacs.[2]

Genetic Predisposition

There is a body of evidence indicating a genetic predisposition to Kaposi's sarcoma.[5] The association between Kaposi's sarcoma and the histocompatibility antigen DR5 appears to be the strongest evidence in humans for the involvement of the major histocompatibility system with susceptibility to a particular form of cancer.[12] This correlation holds true not only for the homosexual form of the disease, but the DR5 has its highest frequencies in blacks, Italian and Jewish populations, with the greatest prevalence in classic Kaposi's sarcoma.[5]

Homosexual Behavior

Another risk factor common to homosexuals who develop Kaposi's sarcoma appears to be extreme promiscuity.[15] An extreme number of sexual partners may increase the chances of exposure to infectious agents. As mentioned, sexually transmitted diseases might contribute to immunosuppression as well as increased exposure to oncogenic viruses. The sexual behavior of the male homosexual plays a profound role in this increased incidence of sexually transmitted diseases. Contact between penis, anus, mouth and hands of either or both partners often occurs with roles sometimes being reversed during the same sexual act.[16] Mouth-anal contact is not uncommon and is thought to contribute significantly to the high number of diseases caused by bowel pathogens.[16]

Another complication of male gay sexual behavior is the anonymity between partners.[17] Infected persons may have no opportunity to warn partners with whom they have been in contact.[17] This behavior could lead to a significant health hazard if, in fact, AIDS and Kaposi's sarcoma are caused by an infectious agent. The male homosexual, as compared to heterosexuals, is also less likely to seek examination and treatment for sexually transmitted diseases.[18]

Even if both homosexual and heterosexual men are exposed to viral (e.g. cytomegalovirus) infected saliva of their sex partner, the homosexual male (as with females) has the additional risk of exposure via infected semen.[19] Semen appears to pose a greater risk of infection with such virus as CMV than does saliva; and asymptomatic virusemia may persist for a year or longer.[19] It is also possible that anal intercourse is more likely than vaginal intercourse to transmit such viruses and pathogens as hepatitis B, genital warts, and syphilis.[20] A correlation has been found between anal cancer and the practice of anal intercourse.[21]

Model for Cancer

Kaposi's sarcoma in male homosexuals is a potentially interesting model of a viral-transmitted human cancer.[6] The pattern of the disease implies behavioral, infectious, environmental, and genetic factors all may play a part in its etiology. There is also a high incidence of second primary cancers in Kaposi's sarcoma patients, particularly lymphoreticular neoplasms.[6] This association implies that the tumor inducer or promoter in KS patients continues to operate and that the etiopathogenic mechanisms of Kaposi's sarcoma and lymphomas may be similar.[6]

Histology

Many origins have been proposed for the tumor cell in Kaposi's sarcoma including a primitive mesenchymal cell, fibroblast, reticuloendothelial cell, Schwann cell, pericyte, and vascular endothelial cell.[4] There is no general consensus on the cell of origin, but the concept of a reticuloendothelial origin is supported by the association between Kaposi's sarcoma and other lymphoreticular neoplasms.[6] The sarcoma tends to be multifocal rather than metastatic.[6] No variation in histological features has been found between classical Kaposi's sarcoma and that seen in gay men.[1]

Summary

The question remains as to the cause and effect of the recent outbreak of AIDS and Kaposi's sarcoma in homosexual men. The cause cannot be traced to homosexual behavior and sexually transmitted diseases alone, since homosexual behavior and the various pathogens associated with it have been around for some time and do not alone explain the recent epidemic. Possibly the carcinogenic and immunosuppressive effects of amyl nitrite may play a role since its widespread use has only come into existence since the 1970s. Nitrites are mutagenic in the Ames test,[12,13] but no correlation has been found with the less commonly used butyl nitrite and Kaposi's sarcoma, although the lack of association is not definite.[15]

Despite the unique population affected by this unusual epi-

demic of acquired immunodepression and Kaposi's sarcoma, no definite etiology has been identified. The fact that the syndrome is apparently an epidemic and frequently leads to a neoplasm makes it of significant concern, not only in public health terms but hopefully in terms of a model system to study the carcinogenic process.

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Trend to incorporate may soon level off

Some 62% of office-based physicians are currently incorporated, according to a recent article in *Medical Economics*. However, this trend is expected to slow and may soon level off, because beginning this year, unincorporated professionals and businesses with Keogh plans are able to match the tax benefits and contributions of corporate plans.

". . . (T)he long fight over professional corporations has boosted the limits on tax-sheltered retirement plans for everyone," the article states.

Also, following three decades of struggling among the IRS, consumer groups and professional organizations, Congress passed a law in 1982 that cut back to $30,000 a year the amount professional and other corporations can put away for a participant in a defined contribution plan. It also set at $90,000 the maximum annual retirement benefit in a defined plan for retirement at age 62.

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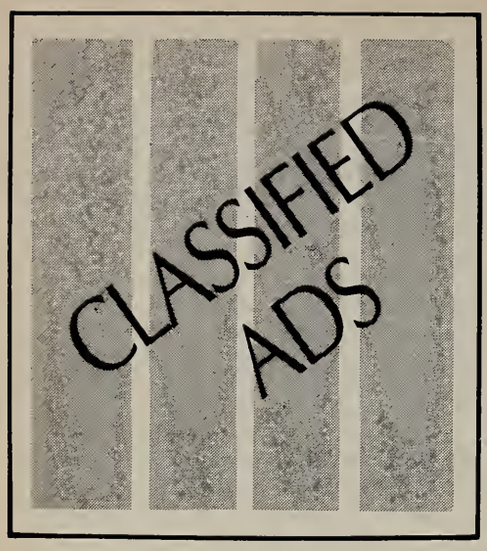
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SPORTS MEDICINE: REHABILITATION OF THE INJURED ATHLETE, March 15, 1984, Westin-Crown Center Hotel, Kansas City, MO. Guest speakers: Barbara J. DeLateur, M.D., Univ. of Washington-Seattle, and James H. McMaster, M.D., Univ. of Pittsburgh. Contact Jan Johnson, Office of C.E., Univ. of Kansas Medical Center, Rainbow at Olathe, Kansas City, KS 66103. (913) 588-4480.

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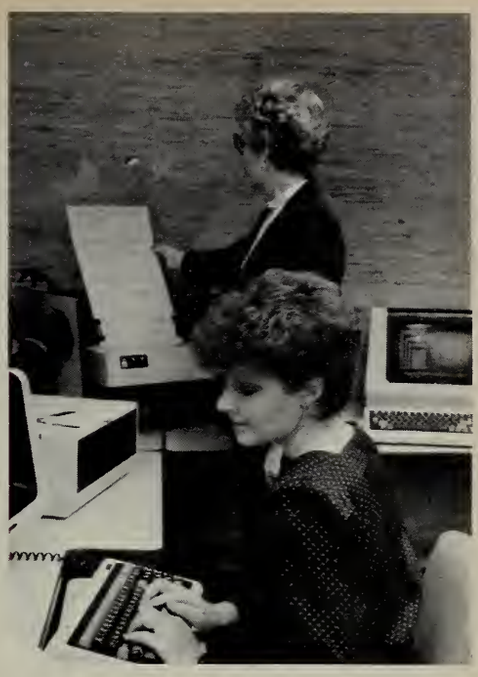
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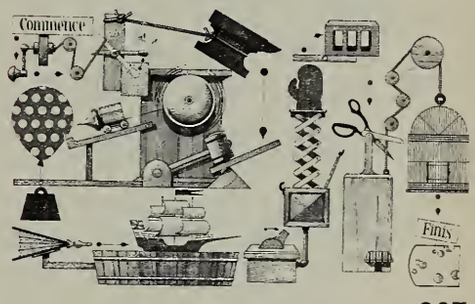
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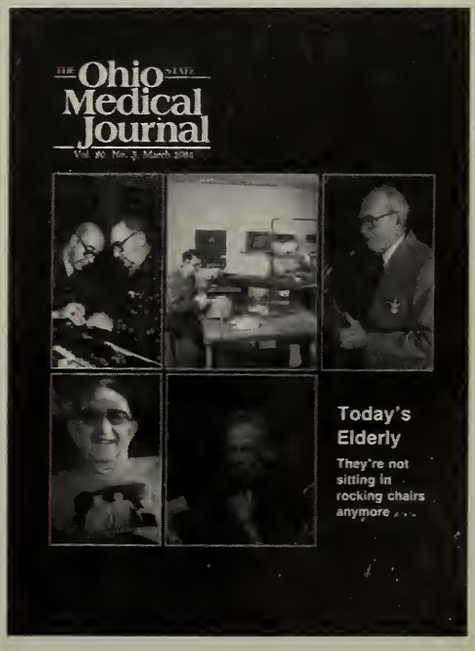
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It Beats The Alternative

By S. Baird Pfahl, Jr., MD

As a general ophthalmologist, I have a wide variety of patient ages with which to deal. The newborns are often seen while still in the hospital nursery, and the elderly are seen in nursing homes. Often, my elderly patients will say, "It's awful to grow old" and my frequent response is, "Yes, but it sure beats the alternative." I thought that I was using that line more often because my definition of elderly changes as I age each year, but statistics show that 11% of our population is over age 65 and that percentage grows larger each year.

As physicians, we must understand that medical care delivery to the elderly presents some special problems. They are not just "old" adults, just as children are not small adults.

As physicians, we must understand that medical care delivery to the elderly presents some special problems. They are not just "old" adults, just as children are not small adults. The physical, mental, social and societal changes are often unique to this group — one, I might add, we all aspire to join. Gerontology as a specialty is growing, and these physicians are helping the rest of us care for our older patients. Age alone should not be a barrier to medical care. When discussing cataracts, I'm often asked "Am I too old to have surgery?" My answer is always: "Not if you *need* the surgery to maintain an appropriate lifestyle and can appreciate the visual improvement." One of my most memorable patients was an elderly man, confined to bed due to bilateral leg amputations. He could not see T.V., nor play his guitar any more, but after surgery he could enjoy his remaining five years of life — he died at age 98.

I was pleased to appoint our first Geriatric Medicine Committee this year and it is chaired by Marshall Werner, MD of Akron. As times goes on, I'm sure Dr. Marshall and his committee will be a strong force in helping all of us provide better, more cost efficient, and more compassionate medical care to our elderly patients. **OSMA**

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Today's Elderly

Out of the rocking chair, onto the streets

Today's elderly are not what they used to be. The stereotyped senior, frail beneath his or her afghan, waiting for whatever fate might bestow, is no more applicable today than the physician who delivers care for a gaggle of geese.

The fact is, today's elderly are out of their proverbial rocking chairs, and onto the streets — and, for that matter, into the spa, the legislature — wherever their active, and often vocal, lives may be leading them.

As an example, we offer the case of one senior we were trying to track down for an interview. His wife was at home, and explained that our potential source was out of town for a few days, attending a regional convention for retired persons, but was expected back on Thursday. Might we call him back then? Well, now, that was the day they volunteered for a local charity, an all-day stint. Then what about the next day? "Sorry, that's the day we deliver meals to homebound elderly." Suffice it to say that we did, finally, get the interview, and it was a good one. But next time, we'll call ahead and schedule an appointment.

The point is, today's seniors . . . one of the fastest growing populations in the country . . . are not the seniors one might typically expect. This group is well-educated, informed and, as health care costs continue to plague the government's Medicare system, anxious to scrutinize the health care delivery system which many of their predecessors took for granted. One thing is certain, however. As the "baby boomers" face their parents' and, eventually their own medical needs, this examination is going to get tougher and tougher.

"People of our generation are not going to accept the health care system at face value anymore," says a geriatric nurse, one of the "baby boomers" who will be rocking the Medicare boat in about forty years. And that seems to be the attitude of the moment.

Today's seniors — the sixty to seventy age group — are movers and shakers. As they reach seventy, eighty and even older, they want the health care system to be there for them, when they need it — and they're willing to do something now to ensure that it will be.

Today's elderly are a complex lot. They are not just patients anymore, and, as physicians begin to see more and more of them in their practices, they are probably going to be asked more questions (about costs as well as care) and see more involvement, as seniors insist on participating *with* the doctor on certain health care decisions. Whether or not the change is for better or worse is moot. It's simply a sign of the times, and this issue of the *Journal* attempts to show you the direction the elderly . . . and care for the elderly . . . is going.

— *Karen S. Edwards*

Letters to the editor

Cost-awareness

To the Editor

I first want to compliment all of you for your outstanding presentation on the cost of medical care in the December issue of the *Ohio State Medical Journal.* The issues were researched, studied and discussed with great skill.

Cost containment seems to be a popular word today, and I would like to suggest two areas where I believe cost containment could be effective.

One of these is in the emergency room. I have the feeling that there is an excessive use of the emergency room, and that the e.r., which was initially meant for emergencies only, has, in many cases, dissolved into what appears to be a treatment facility for regular, clinic cases. This is an expensive format for many simple problems.

I would also like to mention an idea I have concerning patient discharge, which would, perhaps, create some cost-awareness in our profession. At the time of discharge, every doctor has to write a summary of the case in which he or she was involved. I believe the time has come to add a patient profile to this summary, and have it placed on the chart so that the physician can see it. This profile succinctly outlines the entire hospital stay, including diagnosis, and the numerous costs involved in the patient's care. I think it would be very enlightening for each physician to find out how much money was spent (and where it was spent) in the care of his/her patient. Some of these figures are startling. Perhaps, once we've had an opportunity to see for ourselves the cost of medical care, we may all be a little more aware of how the cost is ascending so rapidly — and what all the fuss concerning spiraling health-care costs is about.

I hope to hear some reaction from the rest of my colleagues on this proposal.

Sincerely,
Gilman D. Kirk, MD
Blue Cross
Columbus, Ohio

ADVANCE plan clarified

To the Editor:

Your December, 1983 article "What Third Party Payers Are Doing to Cut Costs" erred in its statement that, "Through programs such as the Blue Shield ADVANCE Plan, participating physicians are reimbursed a set amount for a particular service rendered." ADVANCE Plan is a cooperative agreement between Blue Shield and physicians whereby Blue Shield directs payments for covered services to ADVANCE Plan physicians. In return, Blue Shield asks for doctors' acceptance of our Usual, Customary and Reasonable amount for services covered at the 100 percent UCR level as payment-in-full. Doctors still have the right to bill up to that amount if a contract pays less than the 100 percent UCR level. All physicians statewide are reimbursed under the same UCR system according to the terms of the Blue Shield contract held by their patient. I appreciate this opportunity to clarify Blue Shield's reimbursement mechanism and the ADVANCE Plan program.

Sincerely,
Nettie Petrie
Director, Professional Relations
Blue Shield

An Open Letter to Ohio physicians

To the Editor

Most physicians and nurses would readily agree that teamwork among the two professions is a major factor in the provision of quality patient care.

Too often, good results from physician-nurse teamwork are forgotten as issues of socio-economics, competition and "turf" cloud those of patient management and care. In the words of the old song, it's time to "accentuate the positive." The Ohio State Medical Association-Ohio Nurses Association Liaison Committee is eager to spread the news that patients in Ohio are the benefactors resulting from the cooperative efforts of physicians and nurses at all levels of the health care continuum.

The Committee wants to publish the good news. We need to hear from physicians. We need to hear from nurses. Better yet, we would be delighted to hear from patients whose care stems from coordinated efforts on the part of physicians and nurses.

On behalf of the OSMA-ONA Liaison Committee, we urge physicians, nurses, patients, administrators and others at the point of health care delivery to send us examples of nurse-physician cooperative efforts. The scene could be one of several: physician's office, emergency room, clinic, hospital, nursing home, or at the scene of a major disaster involving injuries.

We would like to offer these positive examples for publication in the journals of the two associations — as well as to publications of county medical societies, constituent nursing districts, and hospitals.

Information may be directed either to the Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, or the Ohio Nurses Association, 4000 East Main Street, Columbus, Ohio 43213.

Sincerely,
OSMA-ONA Liaison Committee
Stewart B. Dunsker, M.D.
Co-Chairman, OSMA
Walter M. Haynes, Jr., M.D.
Marilyn J. Huheey, M.D.
William E. Sovik, M.D.
Claire V. Wolfe, M.D.
Geraldine Price, R.N.
Co-Chairman, ONA
Dorothy Boerger, R.N.
Beryl Chickerella, R.N.
Robert Hershberger, R.N.

Government intervention is not an option either

To the Editor,

I enjoy your column, Second Opinion, and the recent article by Jack Methany, MD ("The Status Quo Is No Longer an Option." *OSMA Journal* January, 1984). If it were intended to be provoking and controversial, it certainly achieved its aim. He mentions a picture of society that has "no vision, no well developed morals and no uniform goals." Of course, the plurality of American society has been one of its features, and I believe, one of its strengths since the time it was first conceived. Indeed, the Constitution is an attempt to guarantee individuals some freedom of expression in their diversity, while not disturbing the common good.

Apart from the discussion of such general issues, several of which I disagree with, he turns on cost control as the main issue facing "health care delivery" today.

I believe that American medicine, as well as American society at large, still has the capacity to adapt, which is typical of "young" civilizations, and to respond to the needs of today. The reason that health care costs are so tremendous is that until now, cost has never been considered a significant factor in medical care, from the first day of medical school until the last day as an emeritus consultant. Now, all of a sudden, attention has been focused on this issue, and I believe that American physicians can and will respond to this.

However, they can do so without a large effect on their own incomes, if the government will stay its hand enough to allow this to happen. Every physician is aware of areas of waste in his/her own practice, and in his/her own hospital, and it is here that the principal savings can be made rather than in physician fees which, with notable exceptions, are reasonable in comparison with other professional incomes.

Doctors alone have the ability to make *constructive* change as opposed to the heavy hand of the state, which in these matters can only make *destructive* change. In other words, doctors can increase productivity and efficiency, while government can only limit resources and payments.

What would government intervention mean? Experience shows us that tinkering with medical care is a favorite with politicians, because although the result may be unhappy for all concerned, they seem to be "doing something." In reality, they essentially limit the availability of resources to the patient by restricting the physician's power to deliver them, either by bureaucratic entanglement or by simple decree. Arbitrary and often nonsensical policies are a feature of centralized medicine, whereas diversity and adaptability are features of private medicine.

Where state medical systems and private medical systems are allowed to compete, private medicine wins hands down on quality and efficiency. Where state medicine has a monopoly, "black market" private medicine flourishes. All indications on a historical basis are that overall, private medicine wins hands down. Only the political advantages to the politicians mentioned above, lead the state to intervene in matters which they know very little about. In attempting to restrict the power of the state, the original authors of the Constitution had more sense than we credit them with.

I agree with Dr. Methany that "the status quo is no longer an option." I do not agree fundamentally with his proposed solution, since it would invite heavy handed intervention by the state, which in other countries and so far in the USA, has demonstrated its incapacity to deal with such a complex problem. I believe the role of the state is to announce clearly and unequivocally that cost is to be a factor in medical decisions, to encourage the efficient deliverers of medical care both verbally and financially, and to promote discussions and teaching sessions on this recent arrival in the list of medical priorities. However, I do not believe the role of the state should be heavy handed intervention. The role of the individual physician should be, I believe, appreciation of the new ethic, absorption and integration of its social aims, and to cooperate with their institutions to introduce the myriad small efficiencies which are going to ensure cost containment and the continuance of private medicine as a way of life.

This approach, of course, is the very antithesis of "defensive medicine," which is itself a direct outcome of the present malpractice-gone-mad situation. Doctors constantly over-utilize hospital facilities, ordering tests, consultations and investigations to cover every diagnostic possibility. The physician rightly views every medical case as a possible malpractice case against him/her, and so "builds his/her defense" by ordering exhaustive testing, without regard for cost benefit. The most effective way the government could help the physician get on with his job of reducing health care costs would be to reduce the ever present sword of Damocles which hangs over every physician's head.

Two features of the American legal system lead to widespread abuse of malpractice litigation. The first is a contingency fee structure, which encourages lawyers to "have a go" in the hope of getting something for their client, and a good deal more than something for themselves from every suit with or without merit. The second is the trial by lay jury, which turns what should be a discussion of highly technical matters in judgment into a courtroom soap opera in an attempt to capture the jury's hearts rather than their heads. Hence, the histrionic posturings of such latter day masters of courtroom melodrama such as Melvin Belli.

Only until the constant threat of trivial malpractice suits is reduced will the basic reason for the defensive posture of present day medicine, and its consequent huge cost to the public, be controlled.

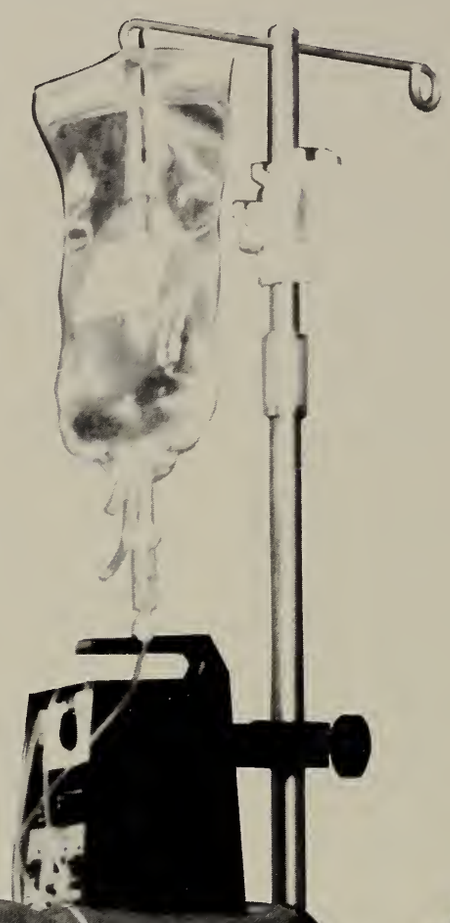
Thank you for your kind consideration to my point of view.

Yours sincerely,
David S. Starr, MD
Youngstown, Ohio

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The Impaired Physician

Where We Are In Ohio And Where We Need To Go

By William J. Kennedy, MD

When William Y. Rial, MD gave his inaugural address on assuming the Presidency of the AMA in 1982, his opening remark was, "I have a concern for thee," in the "friendly persuasion" manner of his Quaker Pennsylvania background. He continued with his concern for the fellow physician who is impaired, with the following: "If the persuasion needs to be a bit more pointed, each physician should recognize that this too involves her or his individual responsibility to the profession as well as to the errant colleague."

We, in Ohio, are fortunate. Thanks to the work of the late Dr. Perry Ayres, we have an Impaired Physicians Program in place with several years' experience, and now is the appropriate time to evaluate its effectiveness.

The program that exists today in Ohio is purposely unstructured. So as to preserve confidentiality, we keep no records. And our efforts in the fields of education and prevention are just beginning. When a physician is reported to be impaired, we have a series of options in dealing with the physician. These range from the first option, which is one of concern but leaving the solution in the hands of the impaired physician, to the last option, which is a statement insisting that the physician receive treatment or the Ohio State Medical Board will be alerted. We have anecdotal evidence of success, but probably a great many impaired physicians go undetected, are identified too late, or receive inadequate or inappropriate treatment.

Our relationship with the Ohio State Medical Board has improved dramatically in the last year under the chairmanship of Dr. Oscar Clarke. Two productive meetings have been held: a one day workshop for the Ohio State Medical Association and the Ohio State Medical Licensing Board; and a second meeting, sponsored by the Ohio State Medical Association, which focused on the family of the impaired physician, medical education and problems of reentry. The appointment of Dr. Deirdre O'Connor, Toledo, an experienced therapist in the field of substance abuse by professionals, to the Ohio State Medical Board is another hallmark of progress. These efforts have literally ushered in a new era of understanding and an opportunity to work in harmony.

We, as physicians, are deeply concerned with state-of-the-art care. The field of chemical dependency over the last decade has evolved into a credible branch of medicine.

Over the last decade a number of states have developed Impaired Physicians Programs that vary widely in structure and effectiveness.

California, recognizing how slowly the wheels of disciplinary boards grind, has developed a fast action network called the Physicians Diversion Program, which utilizes facilitators, usually recovering physicians who are familiar with Alcoholics Anonymous concepts. These facilitators meet twice weekly with impaired physicians for group therapy. The facilitators also evaluate the newly identified impaired physician and forward their recommendations to a Diversion Evaluation Committee which determines the type of treatment program that seems the most suitable and the length of time needed for the rehabilitation process. This program has been in existance for 2½ years and does not yet have a statistically significant data base for the evaluation of its effectiveness.

The Medical Association of Georgia's Disabled Doctors' Program is highly structured and consists of intervention, evaluation, treatment, aftercare, reentry, follow-up, prevention and education. Each component is highly refined. Intervention is done by trained teams that have had an opportunity to gather the appropriate data, and "confronters," trained to make the intervention successful. Evaluation for appropriateness of diagnosis, if necessary, is done on a 96-hour contract in a treatment facility setting where there is strong peer support, (i.e. other physicians dealing with their own personal disease). Treatment is offered in a peer group setting (approximately 50% physicians) so that no one has the opportunity to play God. Aftercare again is done in

peer group settings through the Caduceus Club, which is composed of recovering physicians. Advocacy and reentry can be offered with the credibility that comes from continuing observation over a therapeutically realistic period of time. Prevention and education are done on an ongoing basis in the County Medical Societies, hospital staff meetings and area medical schools. The Medical Association of Georgia's Program has had experience with over 700 physicians and reports a long term follow-up with a high level of success.

We, as physicians, are deeply concerned with state-of-the-art care. The field of chemical dependency over the last decade has evolved into a credible branch of medicine. We now know that effective treatment must be based on our current knowledge of the neurophysiology of addiction. We now know that chemical dependency is not a behavioral problem even though it may appear to be so, and neither is it a psychiatric illness, although it may produce symptoms suggestive of psychiatric illness. It is a primary disease and the treatment must be directed at the primary component, i.e. the addiction. It is time that the Ohio State Medical Association also comes of age in addressing the impaired physician and says, "Yes, I have a concern for thee." If we are to do this in a most effective way we need a major increase in the budget for the Committee on Impaired Physicians. (The largest single line item on the Medical Association of Georgia's budget is their Impaired Physicians' Program.) We need this to hire a full-time physician director who is trained in the field of chemical dependency to strengthen our program in a variety of ways. For example:

1. To establish a statewide network of trained facilitators and intervenors who are comfortable and effective in the process, from data gathering to intervention.

2. To establish and chair two essential committees. First, an Evaluation and Treatment Committee that will evaluate the treatment needs of the impaired physicians, insure that his or her treatment is appropriate and monitor the progress of the recovery process. Second, an Aftercare and Reentry Committee to insure a continuum of appropriate care and serve as a meaningful advocate at the time of reentry.

3. Serve as a resource in the state for education, prevention and assisting in the development of County Medical Societies' and Hospital Medical Staffs' Impaired Physician Committees.

4. To establish a statewide network that will not only improve our liaison with the Ohio State Medical Board, but also upgrade our vital role as advocates in the reentry process.

If we are to be our brother's keeper in a meaningful way, we should select, manage and evaluate his treatment; that is the appropriate role of the physicians, not the role of the patient.

We also need to develop a record keeping system that will remain confidential. We need to recognize that this is a disease of denial and that it is unrealistic to expect sick physicians to assume the most inappropriate role of managing their own treatment. If we are to be our brother's keeper in a meaningful way, we should select, manage and evaluate treatment; that is the appropriate role of the physician, not the role of the patient.

We who specialize in the field of addiction strive to offer the most effective treatment for our patients. We know that this requires structure, no opportunities to fall through the cracks. Should we do less for our colleagues? Without question, this will require additional funding that has not been available in the current OSMA budget. We are addressing a problem that involves 10% to 14% of our colleagues, a disease more tragic than cancer, yet as treatable as pneumonia.**OSMA**

William J. Kennedy, MD, is a member of the OSMA's Committee on Impaired Physicians, and practices medicine in Newark.

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Colleagues In The News

Edited by Ginny Strawser

WILLIAM H. ALLEN, MD, Athens, has accepted another term as President of the Ohio Valley Health Services Foundation.

The Mahoning County Medical Society of Youngstown appointed new officers during its annual meeting at the Youngstown Club. They are: GLENN J. BAUMBLATT, MD, president; JUAN A. RUIZ, MD, vice-president; and KARL F. WIENKE, secretary.

JANE ROGERS FITCH BUTTERWORTH, MD, Youngstown, has been named Director of Rehabilitation Services at Youngstown Hospital Association.

RICHARD COCHRAN, MD, Solon, was appointed to the Red Cross Blood Services Medical Advisory Committee. Dr. Cochran is Division Director of the Donor Center, Blood Bank, and microbiology departments at St. Vincent Charity Hospital and Health Center.

JOHN P. COOK, MD, Sandusky, was recently appointed to serve as president of the medical staff at Good Samaritan Hospital. In addition, Dr. Cook will hold the position of Chairman of the Medical Executive Committee. He will also serve on the By-laws Committee and Credentials Committees.

Lorain County Medical Society in Elyria elected four officers for 1984. The new officers are: RAYMUNDO DE LA PENA, MD, president; KENNETH BESCAK, MD, secretary-treasurer; PETER ESCH, MD, censor; and JOHN SCHAFFER, MD, censor.

PAUL DYMENT, MD, Cleveland was nominated by the American Medical Association Board to serve on the Residency Review Committee. Dr. Dyment specializes in pediatrics.

MASUD SHAH HASHMI, MD, Youngstown, a clinical staff member at Youngstown Hospital Association's Division of Surgery, has recently been named a fellow to the American College of Surgeons.

Lake County Memorial Hospital in Painesville has installed new officers during the annual meeting. They are: GERALD P. HERMAN, MD, president; BERNARD J. ENDRES, MD, vice-president; and JOHN BUKOVNIK, MD, treasurer.

The Stark County Medical Society of Canton has elected several physicians to hold new offices. The new officers are: WILLIAM MARTIN, MD, president; JAMES NIFFENEGGER, MD, president-elect; JORGE ESGUERRA, MD, secretary-treasurer; and ROBERT BATISTA, MD, member of the Board of Censors.



Albert N. May, MD

ALBERT N. MAY, MD, Marion, was recently elected secretary of the Institute of Child Advocacy. The Institute is an independent public interest organization that aims to serve the needs of the abused, neglected and dependent children in the various communities. Dr. May is also the Chief of Pediatrics at Community MedCenter Hospital, and is affiliated with the Smith Clinic.

The Fischer-Titus Memorial Hospital's administration in Norwalk has elected new physicians to hold administrative offices. The newly elected officials are: SHAN A. MOHAMMED, MD, chief of staff; SOUHEIL AL-JADDA, MD, secretary-treasurer; and HAROLD C. SCHULTZ, MD, chief of staff-elect.

The Trumbull County Medical Society, Warren has installed officers at its recent annual meeting. The elected officers are: NIGEL K. NEWMAN, MD, president; ENGLEBERT HECKER, MD, president-elect, and B. JOSEPH TABET, MD, secretary-treasurer.

The Warren County Medical Society of Lebanon has elected new officers. The elected officials are: RAY SIMENDINGER, MD, president; GARY HAYES, MD, vice-president and president-elect; and HOWARD BERNINGER, MD, treasurer.

The administration of Massillon Community Hospital, Massillon, has appointed new officers. The officers are: JAMES A. STANFORTH, MD, president; R. KENNETH LOEFFLER, MD, president-elect; RAHIS LABABIDI, MD, secretary-treasurer; and JOHN A. FRENZ, member-at-large.

ROBERT YOUNG, MD, Johnstown was elected treasurer of the American Association of Family Practice at the 35th annual AAFP meeting.

U.S. feels health care system is ill

Although most Americans believe themselves to be healthy, 30% or some 50 million adults, feel the health care system, itself, is terminally ill and "has so much wrong with it that we need to rebuild it completely," according to a special report issued recently by the Robert Wood Johnson Foundation.

The report, entitled "Update Report on Access to Health Care for the American People," is based on a 1982 comprehensive sample survey of the non-institutionalized U.S. population, conducted by Louis Harris and Associates. It states that while access to basic medical care has improved since a previous national study was conducted in 1976, one million families have at least one member who was refused care for financial reasons during 1982.

The report identifies five population groups that have the greatest difficulty obtaining medical care: the poor, the uninsured, and those in families where the head of the household is unemployed, not in the labor force, or did not graduate from high school.

Black families are less likely than white families to obtain care when they need it, while one in five Hispanic adults (and presumably their children) are among the Americans "in most serious trouble."

On the other hand, the report reveals that the overwhelming majority of Americans enjoy access to a personal physician or other regular source of general medical care. Also, the rates of physician visits and hospital admissions have increased markedly for low-income Americans, particularly since the advent of Medicare and Medicaid in 1965.

Surprisingly, the survey indicates that the difference in health care access between urban and rural populations has nearly disappeared.

Still, more than 28 million people, or some 12%, report serious trouble coping with the health care system and obtaining care when they need it. More than 6.5 million American families, or 9%, have at least one member who has a serious illness. Of those, almost one quarter report that this illness represents a major financial burden for their families.

Public interests changing

The public-at-large is becoming increasingly interested in the impact of technology on human life and is less fascinated with pure advances in medical technology, according to James H. Sammons, MD, executive vice-president of the American Medical Association.

Dr. Sammons makes that statement following a review of the top medical news stories of 1983 — a year in which the emphasis was on information, rather than sensation.

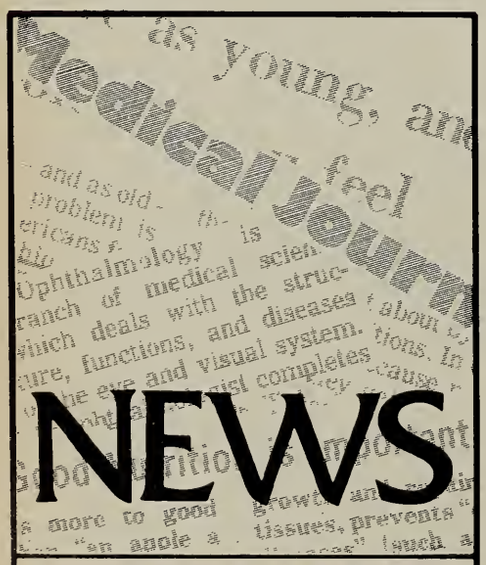
Public attention was focused on the quality (or lack of quality) of life sustained by the world's first artificial heart recipient, Barney Clark, as well as the major difficulties and expenses associated with organ transplants, as demonstrated in the Jamie Fiske case.

The conflict between technology and society moved into the legal arena last year, with several actions related to the "Baby Doe" regulation promulgated by the federal government. Again, "quality of life" was at issue, along with decision-making questions surrounding medical treatment for infants born with lifethreatening birth defects, says Dr. Sammons.

The biggest medical attention-getter in 1983 was Acquired Immune Deficiency Syndrome (AIDS) and the mysteries surrounding its origin, transmission and cure, says Dr. Sammons. The fact the disease is suffered chiefly by homosexuals, IV drug abusers, Haitians and hemophiliacs added further controversy to this difficult issue.

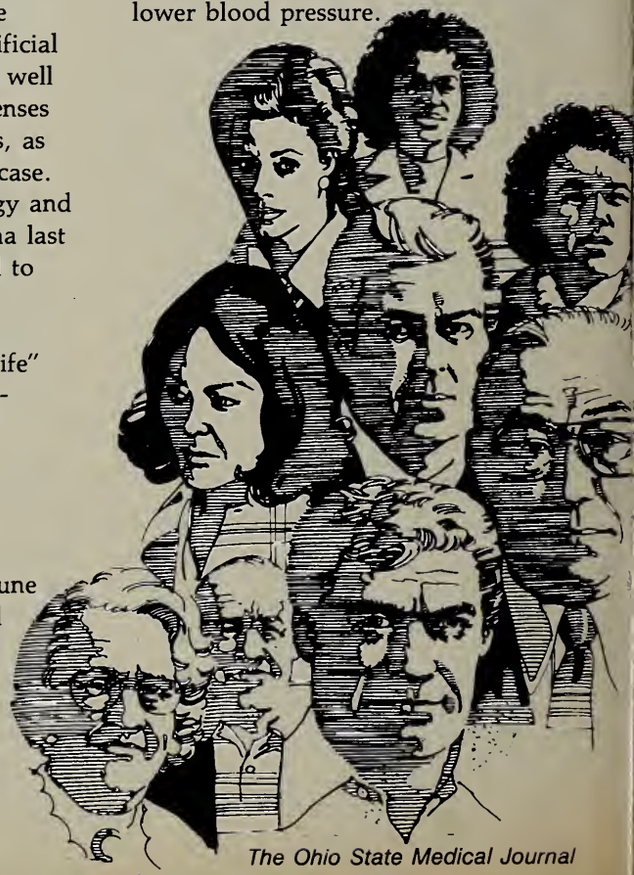
Not all of the medical news in 1983 was bad, Dr. Sammons points out. Advances in human fertility research and studies indicating that oral contraceptives do not cause certain cancers also gained front page headlines.

Also, a report published by scientists in the Netherlands last year provided the first experimental evidence that a lower salt diet leads to lower blood pressure.



a compilation of the latest developments, reports and products of interest to physicians.

edited by Susan Porter





Fallout in farm fields may cause cancer

Historically, Mormons in the State of Utah have experienced 23% fewer cancers than the national average, presumably because they avoid tobacco, alcohol and caffeine and refrain from sexual promiscuity. However, an element added to their atmosphere more than 20 years ago may be increasing their chances of developing cancer, particularly leukemia, according to a recent report in the *Journal of the American Medical Association* (JAMA).

The study indicates that the 4,125 Mormons, living in southwestern Utah between 1951 and 1962 when nuclear weapons were being tested directly upwind in Nevada, have suffered a much greater risk of cancer; 109 more cases of cancer were reported between 1967 and 1975 than were expected from comparison with all Utah Mormons.

Also, these high-risk Mormons experienced five times more cases of leukemia than expected between 1958 and 1966, the study shows, and the high leukemia rates persisted through 1980, as did higher rates of thyroid, gastrointestinal and other cancers. The radiation exposure continues in the area, according to the report, because, "Many persons in this area milk cows and raise their own produce and meat and are exposed to resuspended dust from agricultural activities."

Additional radiation-induced cancers throughout the state can be expected, according to the researcher, as already indicated by an excess of childhood leukemia reported for the entire state.

Mormons make up almost 75% of the state's population.

Case Western researchers study aging

Researchers at Case Western Reserve University School of Medicine have undertaken a three-pronged attack focused on discovering how the nervous system ages at the cellular level. The group recently was awarded a four-year, $1.3 million Aging Program Project Grant from the National Institute on Aging.

The four-member team is looking for answers to causes of Alzheimer's disease and other sicknesses associated with senescence. Because the program at CWRU is well-developed in the area of neuro-cell biology, the research is focused at the cellular level.

The goal for the project, according to one researcher, is to understand the basic principles of the nervous system's functioning. Scientists at CWRU are renowned for their studies of axonal transport of the cytoskeleton.

The research team also has become one of the country's leaders in the study of aging.

MDs blamed

In the face of impending cuts to the Medicare budget, many feel physicians are to blame for rising health-care costs. A recent survey for the American Association of Retired Persons (AARP) shows that two-thirds of the respondents blame doctors for the dilemma, while four out of five believe that limiting doctor and hospital charges is the best way to save Medicare, according to a recent article in *Medical Economics*.

Some 60% of those surveyed support direct state and federal controls on health-care costs.

Teflon tools coming to O.R.?

A rubbery version of Teflon, called Viton, currently is being tested for use on medical tools to prevent the spread of bacteria and infection. Non-stick coatings on medical tools such as urinary catheters could reduce pain and infections by slowing formation of crystals on the surface of the tools while they are being used, one researcher says.

The research is being done by Christopher Batich, a materials engineering professor at the University of Florida. He is testing the non-stick coatings with an electron spectrometer which analyzes the top 20 atomic layers of a material. If successful, non-stick medical devices could someday be as commonplace as non-stick kitchen tools.



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The Peat-Marwick Report

Ohio's Malpractice Climate

Editor's Note:
The OSMA Task Force on Professional Liability recently commissioned a study to analyze the current professional liability climate in the state. The *following* is a report on that study.

A Message from the Chairman

Early in 1975, the Council of the OSMA formed the Task Force on Professional Liability with the original purpose of appraising the professional liability insurance crisis which was facing thousands of members of the Association at that time. The Task Force spent countless hours deliberating with a similar task force from the Ohio State Bar Association and with actuaries, legal counsel, insurance company representatives and government officials in an effort to reach a solution to the problem.

It soon became apparent that the work of the Task Force was becoming increasingly complex and that certain studies needed to be commissioned to assist in resolving the professional liability problems facing the membership. In 1976, the Task Force became a committee of the House of Delegates and was enlarged to include other members of the OSMA. Funding for the Task Force studies became available as a result of a House resolution stating that "The OSMA Task Force on Professional Liability be funded by voluntary solicitation of the OSMA membership."

With funding available, the Task Force commissioned a series of studies, some of which lead to the establishment of a captive professional liability company for OSMA members — Physicians Insurance Company of Ohio (PICO). Other findings and recommendations of the Task Force were embodied in House Bill 682, the Omnibus Medical Malpractice Bill.

Other equally important, but not as apparent, professional liability surveys and studies have been conducted over the past few years. Particular emphasis has been given recently to the possibility of a recurrence of the crisis which swept Ohio in 1975. To assess that possibility, the OSMA Council requested that the Task Force commission do an in-depth analysis of the current professional liability environment in Ohio and predictions for the future.

To insure validity and impartiality of such a study, the Task Force commissioned the highly respected certified public accounting firm of Peat, Marwick, Mitchell, & Co., Chicago, Illinois, to conduct the study.

Peat, Marwick recently completed the report and I'm sure you will agree that it is fascinating reading for anyone interested in what the future may hold in terms of professional liability in this state.

Although the report contains some very interesting and highly enlightening information, one of the most interesting and frankly, surprising findings of the study is the fact that information necessary to conduct an indepth analysis of the professional liability climate in the state is not readily available from public documents filed with the Ohio Department of Insurance.

Space limitations prohibit the Task Force from presenting the entire 60-page report; therefore only the conclusions, the general background, and a review of the Ohio medical professional liability market are presented in this issue of the *Journal*. However, a copy of the entire report is available from the OSMA at $10 for members and $20 for non-members.

The Task Force has spent a great deal of time and effort on this report. Your comments, opinions, reactions and conclusions would be of interest to us and should be sent to the attention of the editor of the *OSMA Journal*.

James L. Henry, MD
Chairman,
OSMA Task Force on
Professional Liability

Ohio's Malpractice Climate

continued

The Report

Dr. James L. Henry
Chairman
Task Force on Professional Liability
Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215
Dear Dr. Henry:

We have completed our review of publicly available financial data related to major medical professional liability insurers in Ohio. The Ohio State Medical Association requested this study in response to reports of concern in other states and by knowledgeable observers of the insurance industry. The purpose of the study is to determine whether such information indicates a basis for concern regarding the stability of the marketplace.

Data

To accomplish our review, we obtained the following data for each of the eight insurers whose 1981 net written premium for medical professional liability coverage exceeded $1 million:

- 1980, 1981 Annual Statements
- 1981 Audit Reports
- The most recent Insurance Department Examination
- Ohio Rate Filings

Analysis

Using this information, we evaluated the results of the following analyses: (1) simple loss reserve adequacy tests; (2) the National Association of Insurance Commissioners (NAIC) "IRIS" and the American Insurance Associations (AIA) "Discriminant Analysis" tests of financial conditions; (3) comparisons of company reinsurance arrangements; and (4) comparisons of company rate filings.

Observations

For the leading national insurers (Aetna, Hartford, and St. Paul Companies) the results of the analyses are so heavily affected by other lines of business, by differences in mixtures of hospital and doctor exposures and by the wide variety of states in which those companies operate that the differences in the analyses among these companies do not appear significant with respect to the Ohio medical professional liability marketplace.

Our observations regarding the medical professional liability specialty insurers, Medical Protective Company (MPC), Ohio Hospital Insurance Company (OHIC), Physicians Insurance Company of Ohio (PICO), PIE Mutual (PIE), and Professional Mutual (PM) are discussed below.

Loss Reserve Adequacy

For the multi-state companies (MPC and PM) and for the primarily hospital insurer (OHIC) the available information is consistent with the conclusion that the companies' loss and loss adjustment expense reserves are reasonable. Naturally an analysis of only publicly available information is not likely to be conclusive on this point.

Prior to 1981, PIE and PICO, the two insurers concentrated in the market we are considering, projected similar loss and loss adjustment expense rations. For 1981 and 1982, PIE has estimated reserves based on an optimistic evaluation of experience. PICO, on the other hand, has chosen to estimate reserves based on a pessimistic evaluation of the same time period. If PICO's projections for 1981-1982 were applied to PIE, then PIE would approach technical insolvency. If PIE's projections for 1981-1982 were applied to PICO, then PICO would recognize after-tax profits which would increase surplus by more than 50%.

The data available to us does not permit us to determine whether one of the assessments is correct for both insurers or whether operating and marketing differences between the companies will lead to results as divergent as those projected in their financial statements. Since the 1981 and 1982 years are immature, it is possible that even a more detailed analysis might not resolve this issue.

Early Warning Tests

The early warning tests applied to 1982 data do not indicate differences among the companies which are significant for the purposes of this study, and they do not indicate an impending "crisis." The latter conclusions must be considered in light of the potential reserve problem discussed in the section above regarding loss reserve adequacy.

Reinsurance

The three Ohio based companies, OHIC, PIE and PICO, are dependent upon reinsurers to cover 40%-50% of their loss exposure. An instability in the availability or cost of reinsurance in the future will therefore likely have repercussions on the stability of the Ohio medical professional liability marketplace.

Furthermore, some of the insurers in this study have reinsurance arrangements in which the amount of ceded premium is adjusted based on loss experience. PIE reports in its 1982 Annual Statements that if reinsurance premiums reached their maximum levels, PIE would owe over $5 million, payment of which would reduce surplus by 97%. None of the other

insurers report contingent reinsurance premium exposurers of the same magnitude. We cannot determine based on the data available to us whether the large potential exposure will in fact be realized, either partially or completely.

Rate Levels

Rate levels vary widely by company. PIE rates are generally the lowest of the five companies. PICO and PM have rates which are 10%-20% above PIE rates. MPC is known in other states as a selective underwriter with relatively low rates. In Ohio, MPC rates in the Cleveland territory and for general practitioners statewide are higher than PICO rates. MPC rates for the remainder of the state are generally between PIE and PICO rates. St. Paul rates and OHIC rates are 50% to 150% above PIE rates.

Our review of Insurance Department files identified actuarial analyses of loss experience supporting the proposed rate levels for OHIC, St. Paul and MPC, the three companies with the highest rate levels. Unless PIE, PICO and PM insure physicians who are significantly different from those insured by St. Paul and OHIC, an actuarial analysis of PIE, PICO and PM experience would likely show that their present rates are inadequate.

Conclusions

Our conclusions with respect to the Ohio marketplace can be summarized as follows:

1. The adequacy of the rates of PIE, PICO and PM is questionable.
2. There is a wide divergence of opinion on the level of losses to be anticipated for 1981-1982 occurrences.
3. The major insurers domiciled in Ohio are very dependent upon the reinsurance market.
4. Adverse developments in any of the areas 1-3 above could result in significant rate level increases for Ohio physicians.
5. There are no conclusive indications of financial problems at any of the major Ohio medical professional liability insurers; however, the continued escalation in claim costs without concomittant premium increases, the divergence of opinion between PICO and PIE regarding 1981-1982 loss levels, and the recent Ohio Supreme Court action reducing the effectiveness of the statute of limitations, are significant signs of potential problems.
6. If financial problems develop, then (1) the national writers, Aetna, Hartford, Medical Protective, and St. Paul seem to be best positioned to absorb the problem, and (2) of the two primarily Ohio based physician insurers, PICO appears to be somewhat more conservatively positioned than PIE.
7. The market has enough participating insurers that, even if financial problems affected one insurer, coverage would continue to be available, albeit at a higher cost. On the other hand, financial problems extending to the reinsurance market could affect the availability of coverage.

* * *

We appreciate the opportunity to have assisted the Ohio State Medical Association with this important project.

Very truly yours,
Peat, Marwick, Mitchell & Co.

* * *

In the mid 1970s, the insurance industry experienced the so-called "malpractice crisis." Medical professional liability claims had been growing throughout the 1960s and the early 1970s. Although moderately troublesome, this growth did not appear to be as severe as other lines of business were experiencing. In a few short years, however, the growth in claims, both in number and severity, exploded at an unprecedented rate.

The timing of this claims explosion, although not coincidental, was unfortunate. This period included the most severe recession since the 1930s coupled with unprecedented inflation. The imposition of price controls during part of this time put additional pressure on insurers. Reserve strengthening was required at a time when insurance companies surplus levels were depleted to low levels because of the depressed stock market.

Faced with extreme pressure on surplus levels, insurers adopted such short-term solutions as the following:

- **Leave the marketplace**
- **Raise rates**
- **Change the form of coverage**

Some companies stopped writing medical professional liability coverage. Others continued to provide coverage, but at rates significantly higher than earlier levels. In other cases, insurers wrote only renewals of existing business, so new doctors or doctors in programs which were stopped had difficulty finding coverage. During this period, claims-made coverage increased in popularity, primarily offered through the St. Paul companies.

The contraction of the medical professional liability marketplace created the twin problems of affordability and availability. Some of the remedies adopted to meet these problems were the following:

- **Going "bare," that is, simply not buying insurance**
- **Self-insurance**
- **JUA's and state funds — joint legislative and insurance industry created "markets"**
- **New specialty companies**

Going "bare" was widely discussed by medical professionals, but it appears that this response is used by only a small percentage of professionals.

Self-insurance became an important tool for dealing with medical professional liability costs for hospitals and health care institutions, where the number of exposures was statistically significant.

Joint Underwriting Associations (JUAs) and other state mandated insurance pools were created in many states in response to the availability crisis. These entities play a "residual" market role in a number of states, but constitute a major part of the marketplace in only a few states.

The dominant new source of medical professional liability insurance for the individual professional is the specialty company. These companies were formed by organized medical professional groups or individual doctors. Most provide only medical professional liability coverage, but a

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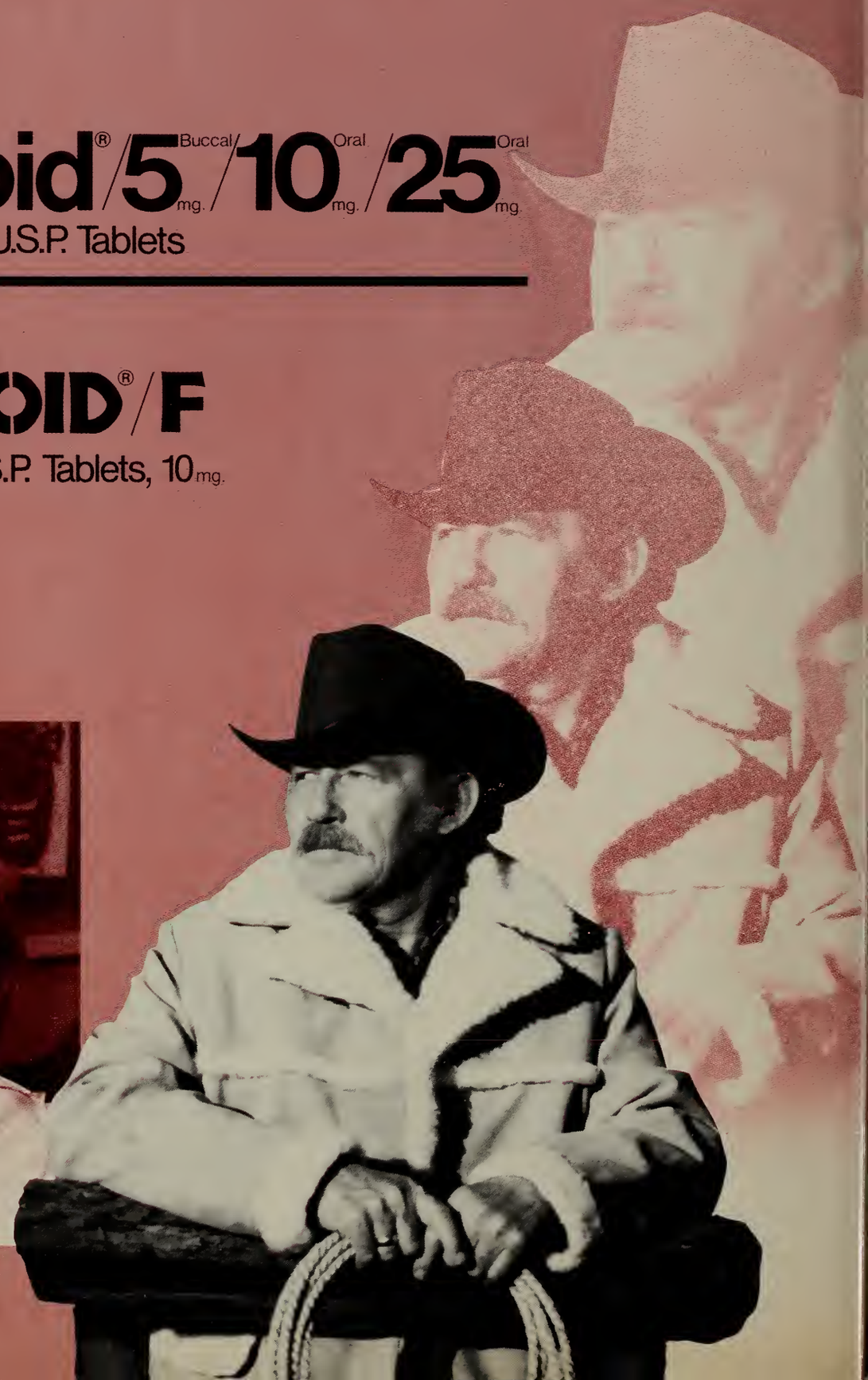
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few also provide other lines of insurance.

General Background

The Ohio State Medical Association, recognizing that efficient operation of the medical profession requires the continued availability of reasonably priced medical professional liability insurance, is concerned that a new "malpractice crisis" may be developing. Actuaries have been concerned for several years. In 1980, the Casualty Actuarial Society's annual meeting included a panel discussion, "Is There a New Malpractice Crisis?"

Best's Insurance Management Reports recently stated, "If there was cause for panic in 1974, 1975, and 1976 over the loss ratios on some of the coverages in the general liability line, 1980 offers ample cause for turning on the alarms again. The liability coverages produced their largest loss in history . . . with medical malpractice . . . the chief culprit." The key questions to be addressed are the following:

- Is another crisis coming?
- Can it be predicted?
- What can be done about it?

To begin to address the first two questions, the Ohio State Medical Association has requested that Peat, Marwick, Mitchell & Co. (Peat Marwick) review the stability of the market for individual medical malpractice insurance.

The Ohio Medical Professional Liability Market

Ohio is the fourth largest state as measured by medical malpractice premium volumes, exceeded only by California, New York and Illinois. The 1981 total premiums for medical malpractice (individual doctors as well as hospitals) were $77 million for the State of Ohio, representing almost 5% of the nationwide premium volume of $1.6 billion.

There are eight insurers who wrote one million dollars of medical professional liability coverage in 1981, according to the Ohio Insurance Department.

They are (listed alphabetically):

Aetna Casualty and Surety Company	Aetna
Hartford Accident and Indemnity Company	Hartford
The Medical Protective Company	MedPro
Ohio Hospital Insurance Company	OHIC
Physicians Insurance Company of Ohio	PICO
PIE Mutual	PIE
Professional Mutual Insurance Company	Pro Mutual
St. Paul Fire and Marine Company	St. Paul

These companies may be categorized several ways. Three of the companies (Aetna, Hartford, St. Paul) are national in scope and write several lines of business other than medical professional. In fact, medical professional accounts for no more than 15% of their total business, as shown in the following chart:

MULTIPLE LINE COMPANIES

	Percentage of Total Business in Medical Professional Liability
Aetna	2.6%
Hartford	1.0%
St. Paul	11.9%

Each of the companies writes less than 5% of its total business in Ohio, as shown in the following chart:

MULTIPLE LINE COMPANIES

	Percentage of Total Business Written in Ohio by Company
Aetna	2.5%
Hartford	1.4%
St. Paul	3.4%

The remaining five companies are specialty writers, specializing in medical professional liability, although related lines of business may also be written. The percentage of business that is medical professional is shown in the following chart:

SPECIALTY COMPANIES

	Percentage of Total Business in Medical Professional Liability
Medical Protective	100.0%
Ohio Hospital	88.6%
PICO	90.9%
PIE Mutual	100.0%
Professional Mutual	97.8%

These companies are predominantly writers of medical professional liability for individual doctors rather than hospitals of similar institutions, with the exception of OHIC.

Approximately 84% of the business written by OHIC is for hospitals and similar institutions.

There is information which can be used to calculate the written premiums for physicians and surgeons in Ohio for six of the eight companies. Two of the companies, Hartford and Aetna, both write modest amounts of medical professional liability in Ohio, but we believe that it is primarily for hospitals and similar institutions.

The share of the total physicians and surgeons premiums written by the eight major companies is shown in the following chart:

	1981 Direct Written Premiums	Share of Total
Aetna	Negligible	—
Hartford	Negligible	—
OHIC	1,757,076	3.7%
Medical Protective	13,990,590	29.7%
PICO	17,806,443	37.8%
PIE	9,068,430	19.3%
Professional Mutual	1,605,927	3.4%
St. Paul	2,850,484	6.1%
TOTAL	47,078,950	100.0%

Of the five specialty writers, three of the companies write predominantly in Ohio, while for the other two, Ohio is a relatively small portion of their market. The percentages are shown in the following table:

	Percentage of Total Physicians and Surgeons Premiums Written in Ohio
Medical Protective	13.9%
OHIC	98.2%
PICO	96.4%
PIE	100.0%
Professional Mutual	16.9%

In summary, the market for physicians and surgeons professional liability can be characterized as follows:

- Two companies, PICO and PIE, which specialize in medical professional liability coverage for doctors, concentrate in Ohio and account for 57% of the total business.
- One company, Medical Protective, which specializes in medical professional liability coverage for doctors, accounts for 30% of the Ohio business, but writes in many

states. Ohio is 14% of its total business.

- One company, OHIC, which writes doctors and hospital medical professional liability coverage predominantly in Ohio, accounts for less than 4% of the total medical professional liability business.
- One company, Professional Mutual, which specializes in medical professional liability coverage for osteopaths, accounts for less than 4% of the total business.
- Three companies, Aetna, Hartford and St. Paul, are multi-line and national in scope; only one (St. Paul) writes any significant amount of the Ohio business.

Data

The sources of data fall into two broad categories — publicly available and not-publicly available. Publicly available data include items such as the Annual Statement, and the examination report of the Insurance Department. Other data, not-publicly available would include interviews with the company personnel, internal claim development data, details regarding reinsurance transactions, details regarding data underlying rate level discussions, etc., as well as other data which they might voluntarily provide. Based on informal discussions with some of the selected companies, we concluded that some of the companies were not willing to provide information that was not publicly available.

Consequently, we (Peat Marwick) decided to restrict our study to information which could be gathered from public documents. We sent letters to each of the eight companies, requesting copies of the following:

1980 and 1981 Annual Statement
1981 Audit Report
Insurance Department Examination (most recent)
Ohio Rate Filings

In the case of companies which declined to provide this information, we visited the Ohio Insurance Department to review the documents on file.

The following chart summarizes the participation of the eight insurers in this study. **OSMA**

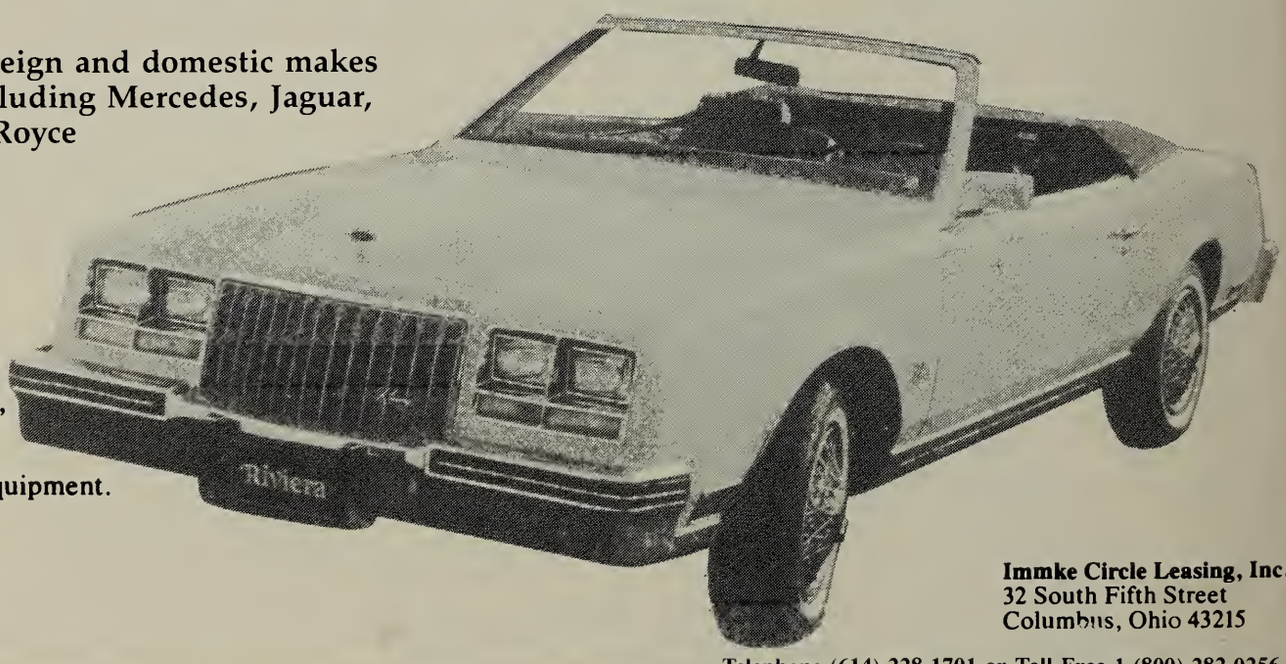
Participation of the Eight Insurers

Company	Participation
Aetna	All data supplied except state examination
Hartford	All data supplied
Medical Protective	Declined to participate
OHIC	Declined to participate
PICO	All data supplied
PIE	Declined to participate
Professional Mutual	All data supplied
St. Paul	All data supplied

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The AMA Interim Report

By Oscar W. Clarke, MD and S. Baird Pfahl, MD

Editor's Note

This report covers some of the important issues voted on by the Ohio Delegation at the 1983 Interim Business meeting of the American Medical Association in Los Angeles, California, December 4-7, 1983.

There were 52 reports and 128 resolutions considered by the House of Delegates. Two of the resolutions were introduced by members of the Ohio Delegation.

Therapeutic Substitution

In lieu of the Ohio resolution submitted by Oscar W. Clarke, MD, Chairman of the Ohio Delegation, Therapeutic Substitution, the following substitute resolution was adopted by the American Medical Association House of Delegates:

"**RESOLVED,** That the American Medical Association vigorously oppose any concept of pharmaceutical or therapeutic substitution of drugs by pharmacists; and be it further

RESOLVED, That the Association urge state medical societies to oppose actively state legislation that would authorize pharmacists independently to dispense pharmaceutical or therapeutic substitutes to a physician's prescription."

The Ohio Delegation supported adoption.

Legal Counsel for Medical Staffs

The Ohio resolution submitted by Robert N. Smith, MD, Vice-Chairman of the Ohio Delegation, Legal Counsel for Medical Staffs, was amended and adopted as follows:

"**RESOLVED,** That the American Medical Association strongly recommend that hospital medical staffs retain their own attorneys so that the medical staff will have its own legal advocates to guide them; and be it further

RESOLVED, That chiefs of staff, administrators and board of trustees be notified of this action by appropriate means."

The Ohio Delegation supported adoption.

Physicians' Freedom to Establish Their Fees

The AMA House of Delegates adopted an amended Board of Trustees Report that describes current pressures from governmental and private sectors to control payment for physicians' services, its continuing effort to preserve the physicians' right to set a fair fee for his/her services and emphasizes that the contract for care and payment is between physician and patient. The amendment to the report is as follows:

"The American Medical Association affirms that it is the right and privilege of each physician to set fees for service that are reasonable and appropriate while always remaining sensitive to the varying resources of patients and retaining for the physician the freedom to choose instances where courtesy or charity could be extended in a dignified and ethical manner."

The Ohio Delegation unanimously supported adoption.

Payment for Physicians' Services

The AMA House of Delegates adopted an amended Council on Medical Service Report in lieu of five resolutions on payment for physicians' services. An additional resolution on this subject was referred to the Board of Trustees.

Following are the conclusion and recommendations contained in the report as adopted:

Conclusion

"In the Council's view, the common thread pervading discussions of this subject since the 1983 Annual meeting appears to be recognition that there are problems for both patients and physicians, created by the UCR approach to establishing third party payment levels, but that alternatives to or modification of the UCR approach must receive further investigation. Currently there is a lack of consensus as to whether an across-the-board change to indemnity-based payment represents the best approach to resolving these problems, and to assuring that control of the quality of care remains with the physicians and

their patients rather than passing by default to third parties.

Accordingly, the Council believes that investigation of alternatives should continue, as the basis for further recommendations to the House of Delegates on this subject at the 1984 Annual Meeting. The Council will benefit from the opportunity to study further the responses and suggestions received from the federation to date, as well as to evaluate additional responses as they are received.

However, the Council continues to believe strongly that physicians' freedom to charge what they believe to be fair and equitable fees should be preserved, and that such freedom carries with it the duty to be responsive to the needs of those in reduced economic circumstances.

Recommendations

Based on its continuing careful study of this issue, the Council on Medical Service recommends:

1) That the American Medical Association recognize the validity of a pluralistic approach to third party reimbursement methodology and that indemnity reimbursement, schedule of benefits, as well as 'usual and customary or reasonable' (UCR), have positive aspects which merit further indepth study.
2) That the Association continue its analysis of the merits of indemnity-based, UCR, and other approaches to establishing such payment amounts under fee-for-service, and that such investigation also continue at other levels of the federation as the basis for additional comment to the Council and further recommendations at the 1984 Annual Meeting.
3) That the House of Delegates reaffirm Association policy supporting: (a) freedom for physicians to choose the method of payment for their services and to establish fair and equitable fees, (b) freedom of patients to select their source of care, and (c) neutral public policy and fair market competition among alternative health care delivery and financing systems.
4) That the House of Delegates reaffirm Association policy encouraging physicians to volunteer fee information to patients, and to discuss fees in advance of services where feasible.
5) That the American Medical Association urge physicians to continue and to expand the practice of accepting third party reimbursement as payment in full in cases of financial hardship, and to voluntarily communicate to their patients through appropriate means their willingness to consider such arrangements in cases of financial need or other circumstances."

The Ohio Delegation unanimously supported adoption.

Balance Billing

The AMA House of Delegates adopted the following amended resolution:

"**RESOLVED,** That the American Medical Association House of Delegates support the right of the physician to balance bill a patient for any care given, regardless of method of payment where permissable by law or contractual arrangement."

The Ohio Delegation unanimously supported adoption.

Explanation of Medicare Benefits (EOMB) Form

The AMA House of Delegates filed a Council on Medical Service informational report detailing changes in the Medicare EOMB form effective October 1, 1983, which the Council finds far more accurate and acceptable than previous versions. The changes in the Medicare EOMB form have achieved a long-sought-for improvement in Medicare communications.

The Ohio Delegation unanimously supported filing.

Development of a Medicare Prospective Payment Pilot Program for Physicians

The AMA House of Delegates referred to the Board of Trustees the following resolution:

"**RESOLVED,** That the American Medical Association work with the Department of Health and Human Services to develop a pilot program which would establish a prospective payment system based on diagnostic related groups (DRGs) for physician organizations for coverage of both the physician and hospital components of care for the inpatient treatment of Medicare patients; and be it further

RESOLVED, That the results of the pilot program be fully analyzed and reported to state, county and specialty medical societies as well as to policymakers prior to any implementation of the program on a larger scale; and be it further

RESOLVED, That the AMA develop an organizational mode for physicians based on the results of the pilot program; and be it further

RESOLVED, That the AMA thoroughly inform state, county and specialty medical societies of the details of model organization."

The Ohio Delegation was split in its vote on referral.

Support of Private, Individualized Medical Care

The AMA House of Delegates adopted the following amended resolution:

"**RESOLVED,** That in order to offer the highest quality of medical care at reasonable cost, the AMA reaffirms its conviction that there should be:

(1) private, individualized medical care;
(2) free enterprise insurance mechanisms;
(3) a specific degree of direct patient responsibility, with
(4) pluralistic, free choice options."

The Ohio Delegation unanimously supported adoption.

Care of Handicapped Newborns in Hospitals

The AMA House of Delegates adopted the following substitute resolution:

"**RESOLVED,** That the American Medical Association continue to oppose regulations or legislation which would impose a federal role in the decision-making about the care of severely ill newborns; and be it further

RESOLVED, That the American Medical Association reaffirm the policy found in Opinions 2.10 and 2.11 of the Judicial Council concerning quality of life and terminal illness."

The Ohio Delegation unanimously supported adoption.

Assistance in Completion of Residency Programs

The AMA House of Delegates adopted the following amended

substitute resolution:

The American Bar Association and the American Psychiatric Association expressed opposition to the report which concluded that the insanity defense:

"Has outlived its principal utility, it invites continuing expansion and corresponding abuse, it requires juries to decide cases on the basis of criteria that defy intelligent resolution in the adversary forum of the courtroom, and it impedes efforts to provide needed treatment to mentally ill offenders."

The Reference Committee concluded that the position recommended by the Board is:

- "Rational and thorough in all aspects.
- Will decrease the time and costs involved in criminal trials.
- Will provide greater opportunity for appropriate treatment of the mentally ill."

The Ohio Delegation unanimously supported adoption.

The House of Delegates also adopted a substitute resolution that called upon the AMA Board to continue collaborative efforts with the American Bar Association and the American Psychiatric Association to achieve a common policy position concerning the insanity defense.

DRG Based Prospective Payment

The AMA House of Delegates adopted the following amended substitute resolution:

"**RESOLVED**, That the American Medical Association endorse the concept that any system of reimbursement for physicians' services be independent of reimbursement systems for other providers of health care; and be it further

RESOLVED, That the AMA continue its opposition to expansion of prospective pricing systems until such time as they have been adequately evaluated with respect to their impact on the quality, cost and access to medical care."

The Ohio Delegation unanimously supported adoption.

Support for Legislation to Reverse the Impact of HCFA Reimbursement Policy Which Discriminates Against Physicians in Solo Practice "Covering" Medicare Patients for Each Other

The AMA House of Delegates adopted the following amended resolution:

"**RESOLVED**, That the American Medical Association continue efforts to permit physicians in solo practice, and those in different groups, to 'cover' Medicare patients for each other, and to make it possible for the personal physicians of Medicare patients to bill, and to receive reimbursement for professional services rendered by their colleagues who 'cover' for them."

The Ohio Delegation unanimously supported adoption.

There are many excellent reports presented to the House of Delegates at each meeting, covering a wide range of subjects that are of interest to physicians. These reports, prepared by the AMA Board of Trustees, councils, committees and staff, contain a wealth of information.

A listing, by title, of some of the reports follows. If you would like information regarding any of these reports, please contact the OSMA office.

1. Poison Control Centers
2. Health Care for an Aged Population
3. Satellite Emergency Clinics; Satellite and Commercial Medical Clinics; Practice of Medicine by Investor-Owned Business Corporations
4. Health Policy Agenda for the American People — Progress Report
5. Study of Professional Liability Costs
6. Asbestos Related Illness
7. Surrogate Mothers
8. AMA Policy on Graduates of Foreign Medical Schools
9. Effects of Competition in Medicine: II
10. State Risk Pooling for Health Insurance
11. Early Detection of Breast Cancer
12. Exercise Programs for the Elderly
13. Caffeine Labeling
14. A Physician's Guide to Asbestos-Related Diseases
15. Drug Substitution — Definition of Terms **OSMA**

Oscar W. Clarke, MD, Gallipolis is Chairman, Ohio Delegation to the AMA.

S. Baird Pfahl, Jr., MD, Sandusky is Co-Chairman, Ohio Delegation to the AMA and President of the Ohio State Medical Association.

Please send me the following AMA report(s) listed in the Summary of Actions Report of the 1983 AMA Interim Meeting:

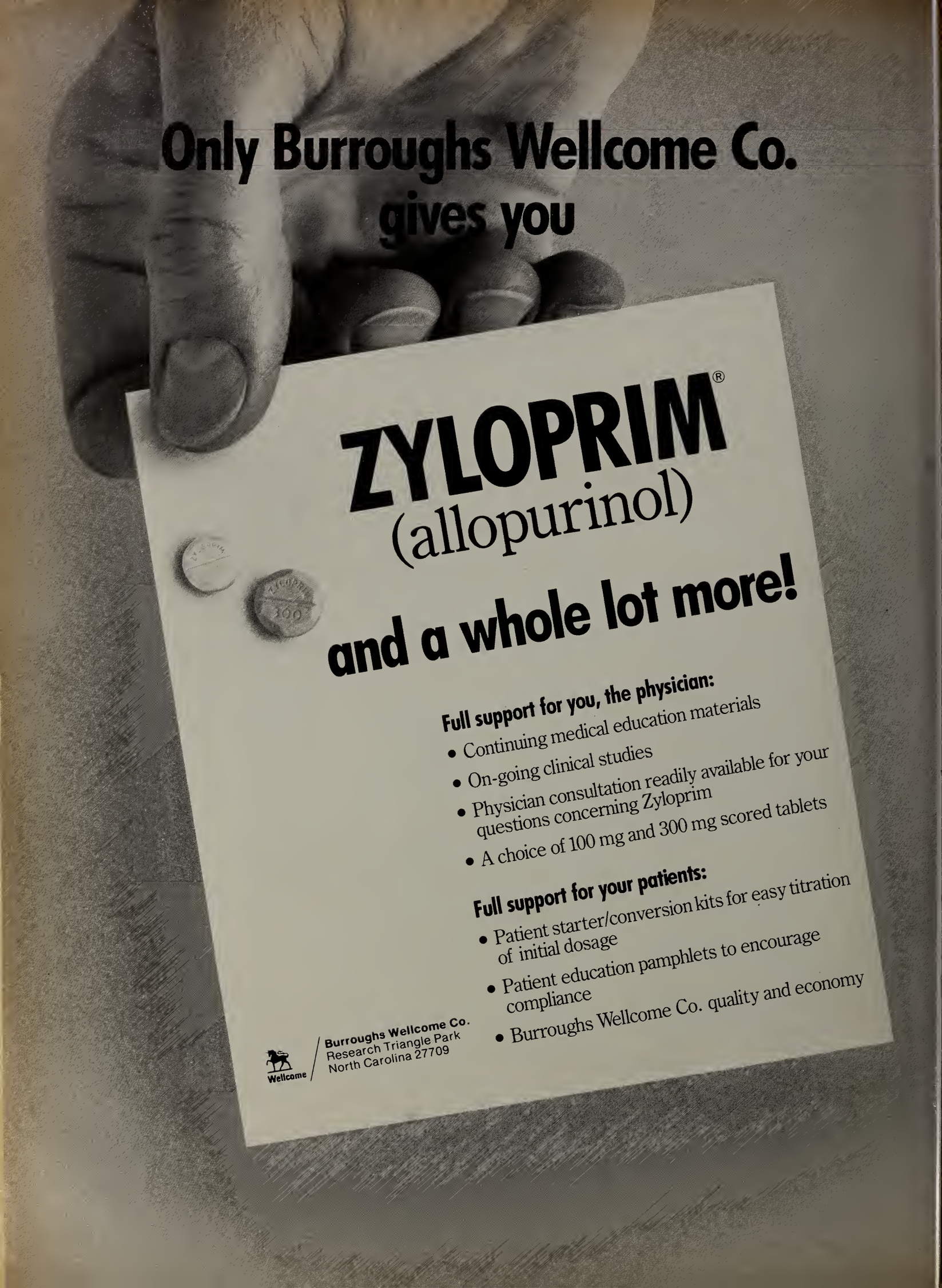
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Does Your Practice Need

A Second Opinion?



By Carol Wright Mullinax

It was an idea whose time had come. That is the way David Pennington, President of the Physician's Administrative Corporation of Ohio (PACO) describes OSMA's decision two years ago to spin-off a practice management company for physicians.

At that time Ohio physicians were just beginning to feel the pinch of increased competition and to cast about for help in addressing the economic issues that practicing physicians face. Responding to this problem, the OSMA took a long hard look at available options. One answer seemed to be increasing the effectiveness and efficiency of the physicians' practice. Although there was much the OSMA could do — and continues to do — in this area, the association realized that much of the work would involve working with individual physicians on an indepth basis. As a result, PACO was established in February of 1982.

Since its inception PACO has kept its original purpose in mind. It began modestly with a system for tape to tape billing of Medicaid, designed to slash turnaround time for reimbursement. With that firmly established, the next step was practice management consulting. This, Pennington says, is where PACO has really made its mark. The stereotype of the physician who concentrates on the clinical side of his or her practice and ignores the business side is often true. Some physicians who contact



Automation is an important and growing part of PACO, as these staff members demonstrate.

PACO often have allowed the business problems to get out of hand. With PACO's help, however, they are able to turn the tide. This often involves analyzing such areas as payment policies for patients, bill collecting, relationship with the hospital and other physicians and relationship with his or her own employees.

Today because of its success in dealing with these problems, PACO is often consulted by new physicians for help in establishing their practices, as well as being called in to "fine-tune" an existing practice.

One reason for its success is PACO's computer system. Pennington says, "You couldn't be in the practice management field very long without realizing that automation was the key to solving many business problems." After completing an analysis of existing computer software programs, PACO decided a year and a half ago to design its own computer system with physician input. As a company owned and operated by physicians, PACO felt it was in an excellent position to design a program that would work in the real world of an office setting.

As a company owned and operated by physicians, PACO felt it was in an excellent position to design a program that would work in the real world of an office setting.

One important way in which PACO differs from other computer firms is that it offers physicians an entire package of programs designed to meet present and future needs. Pennington says other companies are notorious for underestimating needs so the physician initially may spend less for a computer system, but must go back to the well again and again to meet growing needs. "They were being piecemealed to death," Pennington says. The PACO system is large enough and sophisticated enough to meet the physician's expanding needs. "Our lowest priced system is a multiuser with up to six terminals which can be doing different things at the same time. But if a physician only needs one terminal, then that's all he or she pays for. Later on an additional terminal can be added if necessary. With most other computers, if you want to add other terminals, you must expand the computer as well."

PACOs software covers all aspects of a medical practice.

The basic package includes the following programs:

1. **Patient and Insurance Billing** — This includes demand as well as batch statements and insurance claim forms.
2. **Management Reports** — This is an invaluable tool in helping the physician analyze his or her practice. It is capable of generating 20 different reports. This includes analyzing how much income one physician or one procedure is generating.
3. **Patient Scheduling**
4. **Hospital Census Reports** — This helps the physician keep track of hospital patients and even determines the most efficient way to make the rounds.
5. **Payroll and Personnel Management Programs**
6. **Word Processing**
7. **Accounts Receivable Reports**
8. **Communication with other computers,** including AMA Net and CompuServe.

This is important, Pennington says, because often when physicians purchase a computer and software, they usually have only a limited idea of how the computer will be used in the office. So when they pick and choose among available programs, they often make the wrong decisions. They may, for example, decide against a word processing program, and then

a year later decide they need one. They go back to their computer company and find out it will be quite expensive to get the word processing added. If that same physician had a PACO computer system, word processing capabilities would have been part of the original package, and, when the physician was ready to utilize it in his or her office, PACO would be there to help train the staff.

Besides its sophistication, Pennington feels the PACO Computer System is different in one other very important way: As an affiliate of OSMA, PACO is more directly accountable to physicians. When problems develop, Pennington says "We stay with the Doctor." This affiliation has its good and bad points, Pennington concedes. Although it may be a foot in the door to physicians normally wary of computers, PACO is also held to a higher performance standard than other companies. As an OSMA affiliate, it has to get things right.

That's why before recommending a computer, PACO does an exhaustive office analysis. Approximately 22% of the time PACO tells physicians that a computer is not suited to their needs. At least part of that recommendation is based on the fact that PACO is unable to show the physicians an identifiable return on their investment. Pennington says, "That's important when there's that much money involved."

Although Pennington has reason to be proud of what PACO's computer system has accomplished in the past two years, he is quick to point out that he doesn't want PACO identified as a computer company only. "I really look at PACO as a practice management company. The services we provide and the products we sell are management tools to help physicians run their offices more efficiently and effectively," Pennington says.

One important part of that is helping physicians decide where to locate their practice in the first place. PACO is contacted both by physicians trying to decide where to locate and by towns, hospitals and clinics looking for physicians. On physician recruitment and placement PACO often works in conjunction with the OSMA's placement service. One goal for 1984 is to establish a Residency Coordinating and Consulting Service to help Ohio residents make decisions on where to locate.

Other goals for 1984 include:

- **Continuing to expand its product line;**
- **A reconfiguration of its computer to work in large clinic and hospital situations;**
- **Expanding its practice management services to include helping physicians with financial planning.**

PACO also would like to continue to expand into other states. At present, after consulting with physicians in Kentucky and Minnesota, PACO is marketing its computer hardware and software in those states.

Pennington believes the fact that PACO is now being approached by other state medical societies for assistance is a tangible sign that OSMA was "ahead of its time" when it made the move to establish PACO in 1982. "Many physicians are not attuned to economic issues. It is fortunate that, because of OSMA's insight, PACO is here to help." **OSMA**

Carol Wright Mullinax is Associate Director, Department of Communications, Ohio State Medical Association.

PACO Management Seminar

PACO will offer a two-day workshop in Columbus on Wednesday and Thursday, April 25 and 26, 1984, for resident physicians, physicians in an established practice, and their spouses.

The educational workshop will use the case-study method to teach the "how-to's" of writing a business plan for a practice. To be included are:

- How to prepare a budget, based on market data.
- How to establish an efficient third-party reimbursement.
- How to maximize office cash flow.
- Tax planning and management.
- Analysis of competitive forms of practice and reimbursements.
- How to locate and buy a practice, or add a partner.

The first day will emphasize the basics on how to start a practice, to be followed by an evening session on estate and personal financial planning.

The second day will provide information of interest to the established as well as the resident physician.

Contact PACO, 614-885-6666 for further information.

"I look at PACO as a practice management company. The services we provide and the products we sell are management tools to help physicians run their offices more efficiently and effectively."

Agency Reference

To find the PICO agent(s) in your area, consult the listing below.

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Introduction

The Physician and the Elderly

It's Time We Got to Know Each Other a Little Better

By Marshall Werner, MD

We grow too soon old and too late smart. Everyone wants to get older but no one wants to be old. In spite of these facetious truisms, the geriatric age group is growing faster than at any time in our history and will soon comprise the largest single population segment.

With this in mind, OSMA President S. Baird Pfahl, Jr., MD, appointed a Committee on Geriatrics. The committee has explored many of the problems facing the geriatric individual, and has attempted to address those issues we felt to be of prime importance.

Because of the attrition of age, the geriatric individual constitutes a high risk group and one with special problems. Most of the committee recognized this and were of the opinion that a geriatric specialist was probably not the optimum solution, but that a primary physician, caring for this segment, should be cognizant of the different response to disease processes in the elderly, as well as the variation in response to medication in this group.

We also felt that physicians should be made aware of the supportive services which are available to the elderly such as life line, mobile meals, visiting nurse services, rehabilitation centers and hospices.

Transportation, loneliness, heat, housing and many other sociological problems were discussed and felt to be contributing factors to medical problems but outside our venue.

Nothing can take the place of a patient, empathetic physician who is not uncomfortable in dealing with the loneliness of the frequently garrulous, often forgetful patient.

Nothing can take the place of a patient, empathetic physician who is not uncomfortable in dealing with the loneliness of the frequently garrulous, often forgetful patient.

We feel that some progress has been made in the field of medical education, since the Board of Regents began to fund geriatric instruction in the medical schools of Ohio.

This indicates an awareness of the problem in the medical curriculum, but additional CME courses would extend the effort to include the practicing physician segment, which is the larger portion of physicians.

The awareness of ancillary services has been suggested as a secondary educational effort and the assistance of the medical auxiliary of OSMA, as well as the cooperation of the sociologists is being sought. Although their cooperation is already being felt, more awareness is needed as are more physicians, willing to dedicate a portion of their time to this difficult segment of practice.

Our geriatric population deserves it and with a little luck some day so will you. **OSMA**

Marshall R. Werner, MD, Akron, is Chairman of the OSMA Committee on Geriatric Medicine.

Depression in the Elderly

By Victor M. Victoroff, MD

When Maurice Chevalier, the debonair French actor, was asked what he thought of growing old he replied with good humor, "Considering the alternatives, it is wonderful." Unfortunately Chevalier's buoyant and optimistic look at old age is generally not shared. The reverence and respect once given to the elderly has given way to indulgent tolerance, impatient accommodation, degenerating to outright hostile rejection. This change in attitude is especially destructive because it impacts on a group which fifty years ago comprised about 2½% but now involves 10% of the population, increasing annually. Elderly people are at high risk for physical and mental illness, and as such, comprise a serious public health problem which the health-helping professions do not manage well. This is particularly true for depression.

At least 30% of persons over 65 years of age suffer clinical depression. The statistical frequency of depressive symptomatology is greater over the age of 60, and they have more medical illness, take more drugs, suffer more personal losses, and are more vulnerable to nutritional, vitamin, and mineral insufficiency than any other age group.

Suicide risk

The risk of suicide increases in all depressive illness and suicide prone depressed elderly are particularly heavy users of the health care system, accumulate medication, are accident prone, and substance abusers, including of course, alcohol and sedatives.[16,17] Aged persons who lose control of their lives recognize a state of helplessness and dependency. When they become hopeless, suicidal behavior is an inevitable increased risk. For the helpless and hopeless who feel that the ropes that hold them to life are unraveling and falling away, suicide seems completely rational. Self-destruction is most prevalent over age 65, where the rate is over 10,000 per year, comprising 25% of all suicides.

Sharpening our diagnostic abilities to recognize those who can be rehabilitated is a worthwhile exercise in preventive medicine.

Sometimes the elderly disguise a suicidal act by drug overdose, mixing drugs, failure to comply with treatment protocol, and starving themselves to death. Particularly vulnerable times during the year are the anniversary of the death of a spouse or a close friend. Elderly widowers are at greater risk than widows. It is suggested that women who survive better than men do so because they integrate kinship group relationships, but widowers have generally not done this in their adult family life, and cannot learn when the wife dies. For the 65 to 69 year old, the suicide rate is four times that of the younger population, and by 85, it is twelve times greater.

Depression causes difficulty in maintaining social activity, loss of interest in games, hobbies, sports, inability to sustain emotional intimacy, a decrease in sexual interest, which may be manifested by sexual impotence. As a result of maladjustment and social dislocations, unemployment, professional failure, and divorce may result. Frequently families do not realize that they may be ignoring a treatable condition. As the elderly lose their assets such as their adaptational ability, experience reduced mastery over parts of their body, and lose job, earning power and libido, interest in life falls away and the family members may attribute this to "senility." Often the condition is the result of depression, the course of which will be determined by whether or not dysphoria is recognized. Left alone, somatic disease, suicide attempts, hospitalizations, deepening dysphoria, may result.

Although the rate of psychiatric disorders increases with age, as does suicidal risk, it is noteworthy that elderly patients are not referred for



psychiatric hospitalizations as often as are younger patients.[20] This underlines the loss to society of potential contributors which many of the elderly can be. Because of prejudice, an attitude is perpetuated which unfortunately extends to the health care takers who assume, with the ignorance and arrogance of youth, that old age is synonymous with wretched uselessness. Sharpening our diagnostic abilities to recognize those who can be rehabilitated is a worthwhile exercise in preventive medicine.

The new Diagnostic Related Groups criteria accenting cost containment rather than quality of care; the bias of third party payers against the "chronically ill"; the pressure of hospital utilization committees to get the patients out of the hospital; and the high cost of terminal illness puts the physician under pressure. He or she must separate patients who can be rehabilitated and begin to institute a medical program to maximize the patient's return to his or her best potential as soon as possible, a potent reason to learn to recognize reversible illness in the elderly.

Causes of depression

Situational factors unquestionably cause depression as the elderly person loses vital social roles in work, family, politics, and the community. Loss of income, loss of status and prestige, declining health, painful, chronic, debilitating illness, loss of strength, reduction or loss of hearing and eyesight, and personal losses, such as the death of spouses and friends cause disconnection with the past. Loss of communication with intimates results in loneliness, a sense of emptiness, feeling of meaninglessness and uselessness of life, and leads to deep melancholia.

The challenge of the aged patient's demand for relief of insomnia and his/her multiple physical complaints may excite a quick draw syndrome on the part of the doctor who pulls out the prescription pad from the therapeutic holster, then writes



Severe depression may be indistinguishable from dementia. The differential is critical because the pseudodementia of profound dysphoria responds dramatically to treatment.

prescriptions for alleviation of specific symptoms. Drugs are ordered which in themselves may cause or exaggerate depression. These include steroids, antitensive drugs such as aldomet, guanethidine, and beta-blockers as propranolol and reserpine. Glycosides, such as digitalis, lanoxin, and tranquilizers and sedatives, by reason of their depressant effect on the central nervous system, may cause depression.

The recognition of depressive states is compromised by the fact that many old people are concerned about the doctor's feelings and may hide their depression behind an aura of politeness.

Many illnesses such as occult cancer present as depression, but the opposite problem is more likely, namely that the elderly patient will experience emotional distress as somatic pain, and presents himself or herself to the physician with medical illness. It is important to search out depression which may lie behind and is in fact part of the illness.

Our culture places a high value on financial success and social prestige and has little sympathy for the non-achiever and the complainer. However, "being sick" is an honorable state which grants temporary immunity from normal social responsibilities.

The hypochondriac depressive

Neurotic complaints, unacceptable admission of personal failure give way, then, to escape into the sick role until there is eventual recognition that the illness excuse is not justified by objective signs. This conclusion may then lead to impatient rejection, not only by the family but also by the physician.

Even if patients have had a prior history of depression, they are unlikely to admit it readily and present with vague complaints of pain, weakness and functional disability. Yet the signs of depression, loss of appetite, insomnia, particularly early morning wakening, weight loss, and chronic constipation, are all too often the unrecognized symptoms of the hypochondriac depressive often regarded as a "crock."

Emotional and mental disturbances are also evident. Older people complain of loss of social and even sexual intimacy. Impotency in older men is assumed as inevitable but need not occur as an absolute, even if there is relative loss of potentia. Loss of sexual desire is not necessarily caused by the process of aging, but is in itself the result of withdrawal from intimacy and depression.

The patients present as helpless, pessimistic, discouraged, complaining of inadequate functioning in their lives, or may project their pessimism outward with tirades against the world and long histories of having been badly treated. They are separated from true paranoids who believe that their injuries are caused by malicious intent. The elderly rail against their bad fortune and the careless indifference of others. There may be a mix of organic disease with psychiatric illness, but even if the patient seems frail, severely debilitated, and "organic," the physician must persuade himself or herself not to jump to the conclusion that the patient is suffering irreversible disease.

An important subtype of depressive illness is *anaclitic depression.*[10] It is more often diagnosed in children than in the elderly, but equally applies to both. The patient protests in the early phases against his maleficent fate with agitation and angry weeping. This then degenerates to despair which is manifested by signs of hopelessness, but is less obvious to the casual observer. The third stage of detachment is actually dangerous to life and features withdrawal from social contact, anorexia, severe anergy, and total dependency. This is a process which occurs in elderly who experience multiple losses of relationships, sensory deprivation, and physical deterioration, without sustained or nurturing relationships available. By no means are all patients suffering major depression, suffering from anaclitic depression. The crucial diagnostic criterion is the loss of nurturing relationships.

Paranoia is a feature of depression in which illogical suspicion appears, sometimes a reaction to loss. This

symptom is particularly seen with loss of auditory function.[6]

Depression or dementia?

The differential diagnosis of depression from *dementia* begins with an examination of a prominent symptom seen in both, mainly *psychomotor retardation*. This is a term used to describe marked slowing of physical and mental function usually referred to depression but occasionally descriptive of the effects of cortical and subcortical dementia. **Severe depression may be indistinguishable from dementia.** The differential is critical because the pseudodementia of profound dysphoria responds dramatically to treatment.[11] Most dementias which occur as consequences of physical disease, such as multi-infarct or Alzheimer's disease, will not.[14]

A complete physical examination including careful neurological study, laboratory examination, including SMA-18, EKG, CAT scan of the brain, electroencephalogram, thyroid function study, and of course a competent and far-ranging history begin the differential diagnosis.

The dexamethasone suppression test, although controversial, may enhance a physician's confidence in making a current diagnosis or evaluating the usefulness of a trial of treatment.[4] In organic brain disorders, sleep studies with the electroencephalogram show shortened Rem latency, increased Rem activity and density.[12] Psychological testing may give clues separating organic from psychological deficiencies.

Referral to the psychiatrist for collaborative evaluation and treatment of the patient is an option for the physician to consider.

Many elderly depressed patients enter the treatment module with crisis intervention, usually presenting as physical illness. It is important to allow the patient to ventilate his/her feelings about a particular event and then give empathetic understanding and explore alternative courses open to the patient and the family emphasizing the importance of more than one alternative which may present.[21] The family members who bring the patient suffer as much as the patient. The physician must consider the family in alleviating guilt and apportioning responsibility for care at all stages of treatment. As the treatment plan is maturing, consideration for other agents available to the physician will augment his/her own skills. Collaboration with other specialists such as the ophthalmologist and audiologist, the psychologist, the psychiatrist, social worker, the physical and occupational therapist and eventually the home care nurse give important useful adjunctives in the treatment design.[17]

After due attention is paid to the risk for suicide,[15,16] consideration is then given to drugs, shock therapy, psychotherapy, revision of the patient's social state, improvement of nurturance, and then lastly consideration of the patient's legal status.

Best probability of cure

Anti-depressant and anti-psychotic prescriptions make the patient accessible for contact. But it is human contact and nurturance of relationships that leads to the best probability of cure.

After unnecessary medications have been terminated and this certainly includes sedatives, tricyclic anti-depressants should be considered.[2,3] They seldom worsen the organically impaired who are depressed, and when given in the evening, promote sleep.

Monoamine oxidase inhibitors are particularly useful but along with tricyclics do cause side-effects, such as oversedation, dry mouth, orthostatic syncopy, and obstipation, sometimes leading to intestinal ileus. The MAOI drugs must be carefully monitored to avoid the complication of hypertensive crisis induced by the combination with tyramine, an amino acid occurring in foods.[8,21]

Although seldom employed, elderly patients may tolerate ritalin and even amphetamines and show improvement in their awareness, vitality, and reduction of physical complaints.

Electrocardiogram should be monitored, looking for prolonged interventricular conduction defects because the tricyclic anti-depressants significantly increase cardiac conduction time and heart block is a contraindication for the use of these drugs.[4,9] A predisposition to orthostatic hypotension causing dizziness and falling, and vulnerability to anticholinergic side effects are particularly significant in the aged with complaints of prostatic disease, glaucoma, and obstipation. Doxepin has less hypertensive and anticholinergic effect and desipramine is less sedative.[3]

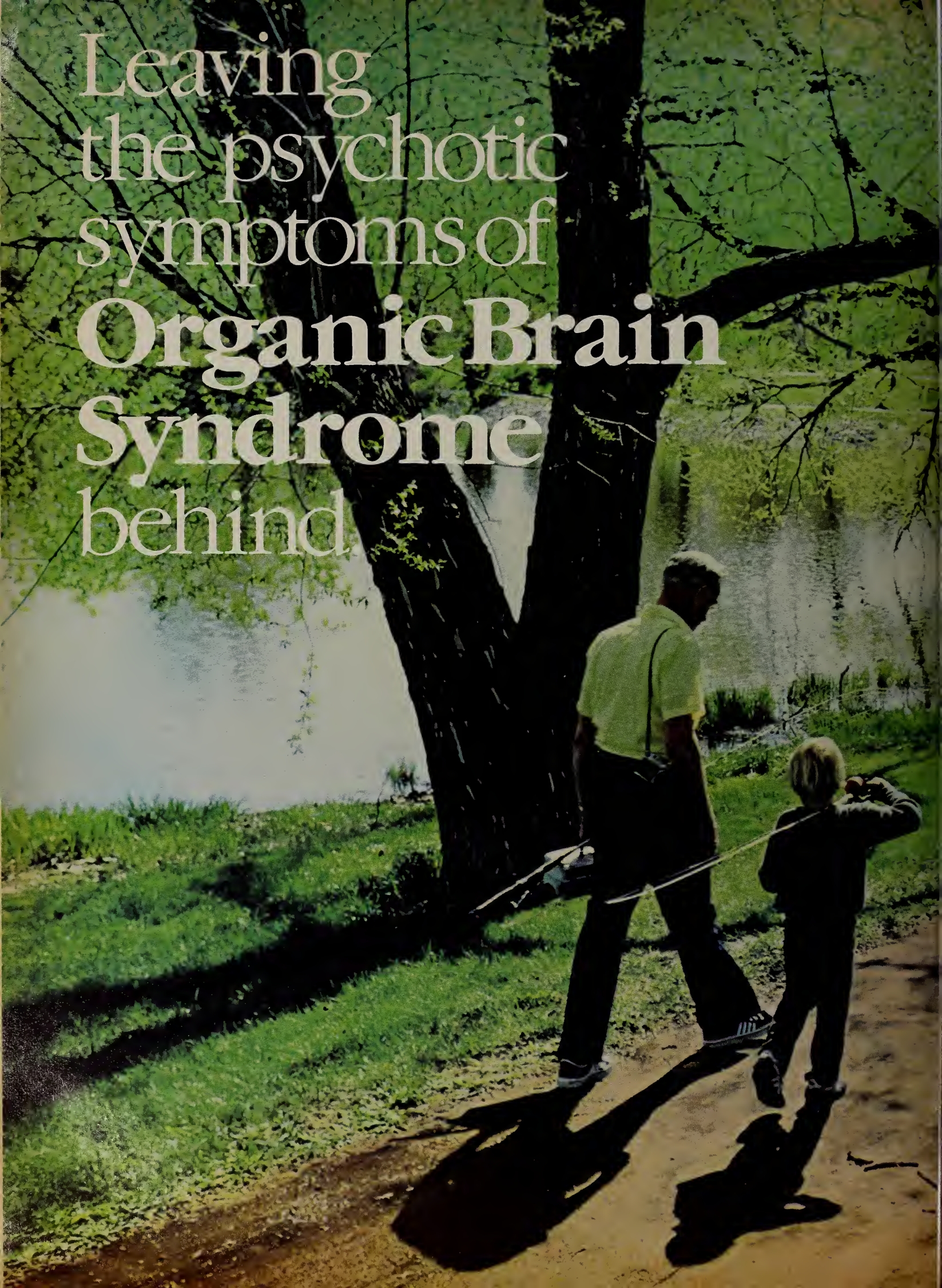
When there are psychotic features such as delusions this virtually eliminates the use of tricyclic anti-depressants alone. The TCA's must be combined with neuroleptics, such as thiothixene, trifluoperazine or phenazine.

Bi-polar affect disorder may at times appear with psychotic symptoms, usually mood congruent delusions. Lithium may be combined with the TCA's. The toxicity factor must be carefully evaluated and monitored. Any decrease in awareness or clouding of sensorium should require lowering or discontinuing lithium.[2]

Electroshock therapy is frequently the technique of choice in affective disorders in the senium. When medical illness and sensitivity to drugs contraindicate pharmacological treatment, or when a fair trial of drug therapy has been unsuccessful, elderly patients deserve a trial of this essentially safe and effective treatment modality.[7]

Not only the psychiatrist can administer psychotherapy but anyone in the health care professions can offer empathy and understanding to the elderly. Decline of self value is a primary target. Improvement of resources and accentuation of retained skills should be reinforced, such as sexual desirability, strength, work performance, ability to get and retain possessions, artistic skills, and previous reputation and independence. Pharmacotherapy combined with psychotherapy is more effective and lasting than pharmacotherapy alone.[6]

continued on page 187


Leaving
the psychotic
symptoms of
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Syndrome
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Effective

Treatment with Navane can produce improvement in psychotic symptoms such as hallucinatory behavior and unusual thought content as well as hostility, disorientation and depressive mood,[1,2] leaving the elderly patient more alert[2] and better able to participate in the activities of family life.

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Navane is generally well tolerated by elderly patients. Excessive sedation or drowsiness has been reported, but is uncommon.[1] Anticholinergic effects[3] and hypotension[4,5] are reported, but rarely. Should they occur, extrapyramidal symptoms can usually be readily controlled.

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See following page for a brief summary of prescribing information

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References: 1. Util TM, Unverdi C. Wohlrade J, et al: Drug therapy of psychosis associated with organic brain syndrome. Presented as a Scientific Exhibit at the American Public Health Association Centennial, Atlantic City, New Jersey, November 12-16. 1972. 2. Katz MM, Util TM: Video methodology for research in psychopathology and psychopharmacology. *Arch Gen Psychiatry* 31:204-210, 1974. 3. Ketai R: Psychotropic drugs in the management of psychiatric emergencies. *Postgraduate Medicine* 58:87-93, 1975. 4. Birkett DP, Hirschfield W, Simpson GM: Thiothixene in the treatment of diseases of the senium. *Curr Ther Res* 14:775-779, 1972. 5. Data on file at Roerig.

BRIEF SUMMARY OF PRESCRIBING INFORMATION
Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
(thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular: 2 mg/ml, 5 mg/ml
Contraindications: Navane (thiothixene) is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but the possibility should be considered.
Warnings: *Usage in Pregnancy*—Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration of Navane to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in Children—The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.

Precautions: An antiemetic effect was observed in animal studies with Navane, since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy, and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis) have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Neuroleptic drugs elevate prolactin levels; the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis; the available evidence is considered too limited to be conclusive at this time.

Intramuscular Administration—As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e. gluteus maximus) and the mid-lateral thigh.

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Adverse Reactions: *Note:* Not all of the following adverse reactions have been reported with Navane (thiothixene). However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used.

Cardiovascular effects: Tachycardia, hypotension, lightheadedness, and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines. The clinical significance of these changes is not known.

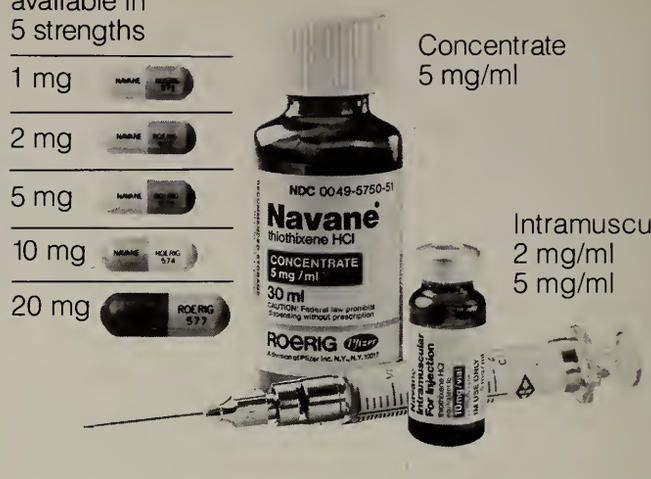
CNS effects: Drowsiness, usually mild, may occur although it usually subsides with continuation of Navane therapy. The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane (thiothixene). Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudo-parkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia: As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.



There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Undue exposure to sunlight should be avoided. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

Although not reported with Navane, evidence indicates there is a relationship between phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrome.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration.

Dosage and Administration: Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition. In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on once-a-day Navane therapy.

Usage in children under 12 years of age is not recommended because safe conditions for its use have not been established.

Navane Intramuscular Solution: Navane For Injection—Where more rapid control and treatment of acute behavior is desirable, the intramuscular form of Navane may be indicated. It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg/day. An oral form should supplant the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane (thiothixene) Capsules and Concentrate appear in the following paragraphs.

Navane Capsules: Navane Concentrate—In milder conditions, an initial dose of 2 mg three times daily. If indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg twice daily.

The usual optimal dose is 20 to 30 mg daily. If indicated, an increase to 60 mg/day total daily dose is often effective. Exceeding a total daily dose of 60 mg rarely increases the beneficial response.

Overdosage: Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, hypotension, disturbances of gait, or coma.

Treatment: Essentially is symptomatic and supportive. For Navane oral, early gastric lavage is helpful. For Navane oral and Intramuscular, keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors.)

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of the blood pressure.

If CNS depression is present and specific therapy is indicated, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Stimulants that may cause convulsions (e.g. picrotoxin or pentylenetetrazol) should be avoided. Extrapyramidal symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

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A division of Pfizer Pharmaceuticals

Psychotherapy needed

It is an error of prejudiced judgment which presumes that since aging results in instability, decreased memory, dysphoria, and social withdrawal, psychotherapy isn't warranted and won't work. As a result many patients suffering from exogenous depression who should receive psychotherapy will never obtain it. The therapeutic bond is a lifeline to support the patient until he can form new relationships and find new alternatives to pessimism and self-negation. A frequent spin-off of effective psychotherapy is improved physical health and capacity for self-care and increased activity in daily life.

As possible, losses should be replaced with new sources and the environment structured to enhance support of the family. In order to do so, families which manifest tension in their attitude to the aged sick may require family therapy.[18]

After the patient has had an integrated experience with a one-on-one psychotherapist, social integration can be sought. Substitute relationships for those that have been lost, alternative housing, improved familarization with new living arrangements, offer enduring adaptations for the older person's needs. The Grey Panthers, for example, offer the opportunity for opposing social prejudice and offer a political identity for the aged. Surrogate grandparenting is not only a delight for the children but a life-saving experience for the elderly. There are opportunities for older persons to become companions to other elderly persons who are home-bound or in the hospital and need an outreach to another empathetic person. Many communities have Golden Age Centers and volunteer programs which make the use of the patient's potential for social participation.

For patients who have suffered anaclitic depression, the most important treatment components are touching and loving nurturance.

The physician may be asked to help the family make a judgment whether the patient's ineptitude and loss of function has proceeded to a point where self-care is in question and the guardianship of person, property or both must be established for the benefit of the patient's continued survival. Psychological evaluation may be helpful in establishing the degree of loss of cognitive status and intellectual resources for the legal definition of incompetence to be fairly stated.

Not only the psychiatrist can administer psychotherapy but anyone in the health care professions can offer empathy and understanding to the elderly.

Old people can be helped. The resources of the physician and the psychiatrist, with interest in geriatric, biopsychosocial phenomena are in a unique position to rehabilitate. However, our society needs a cultural revolution to change our perception of the aged from a population of helpless nuisances to realization they can be productive good citizens.[16] **OSMA**

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What Do I Do With My Patient?

Nursing Home Alternatives

By Karen S. Edwards

Now that the diagnostic related group (DRG) reimbursement system — integrated into hospitals late last year as a way of containing Medicare costs — may shorten hospital stays for the elderly, physicians are often left wondering what to do about the elderly patient who still needs care but must be removed from the hospital setting.

Nursing homes are too often crowded, and, like their alter-egos, the "retirement community," they are expensive. There is an argument, too, that "40% of nursing home residents are 'inappropriately institutionalized' " — this according to a national survey taken in 1981.

Fortunately, there are alternative resources out there, and an awakening interest in the elderly has spurred even further developments along this line. By reporting on some of them here, we hope to make you aware of the kinds of options that are available, and those that may soon be available in your community. But beware. Finding these options isn't always easy. Like closely-guarded secrets, they need a little patience and a little persistence to coax them out into the open.

Adult Day Care Centers

These run the gamut from social-recreational centers for those elderly in reasonably good health to restorative programs for victims of stroke and other head-related traumas.

They are funded both publicly and privately, and there is usually a daily charge to those clients attending the centers.

Stumbling blocks are cost (third-party payments are not available to day-care centers that don't offer rehabilitation); and transportation, since it's not usually provided by the centers.

Still, the concept is growing by leaps and bounds, and it is estimated that there are more than 800 such centers nationwide — 53 of them here in Ohio.

Look for them in hospitals, churches, mental health centers, and as independent operations.

Home Health Care

Nursing care is provided in the home by public, private and philanthropic groups. The quality of care ranges from adequate to excellent, and often includes both physical and occupational therapy.

Stumbling blocks are, again, cost — the services provided by visiting nurses are not always covered by Medicare and Medicaid — and long waiting lists.

In looking for this service in your community, you may wish to consider those groups that can also offer additional support programs to your patient — for example, house-cleaning services, home-delivered meals, etc. Also, some groups sponsor home-health courses which teach family members how to care for elderly relatives who may be living at home with them.

Look for these services in hospitals (a number of them have begun to branch out in this area recently); local health departments; and community service groups (generally listed under "Social Services" in the yellow pages).

Clinics

Clinic care is designed for those patients who are ambulatory, but who still need their health monitored on a regular basis. Like adult day care centers, they come in all forms:

nursing clinics, administered by registered nurses who monitor patient health between office visits; geriatric clinics which takes a team approach to health care (usually involving a gerontologist, geriatric nurse and geriatric social worker); and mobile health assessment clinics which visit predetermined sites to monitor health care.

Long waiting lists are really the only stumbling blocks, as many agencies provide these services at nominal costs, or on a sliding scale, relative to the patient's income.

Check hospitals, universities, local health departments and community service groups for this type of program.

Shared Living

This is the area to watch in the future, as more and more elderly, anxious to maintain their independence, yet recognizing that they cannot manage — at least financially, even emotionally — on their own, seek out contemporaries with whom to share their living quarters.

While the project is actually afoot in the east (the Queens, in New York began a pilot program called Homesharing in 1982, and, to date, a total of 18 matches have been made), the idea is still in the blueprint stage in Ohio.

Look for it to get off the ground, soon, though. Check with area Commissions on Aging for what might be planned in your area.

New Frontiers

Many of the more traditional forms of health care, i.e. hospitals and nursing homes, are updating their own programs to respond to the needs of the state's increasing number of senior citizens.

For example, Lutheran Medical Center, in Cleveland, is the only hospital in Ohio — and one of the few general hospitals in the country — to provide emergency psychiatric diagnosis, and treatment, expressly for the elderly.

Riverside Hospital in Columbus has established a special, hospital-based unit expressly for the care of geriatric patients.

Nursing homes, too, are taking strides to keep up with needs of a more demanding clientele (and to keep pace in a competitive market-place filled with retirement communities).

For example, one nursing home in Westerville, Ohio — part of a nursing home operation with locations in four other states — offers its clients a "resort image," complete with Sunday champagne brunches twice a month; cocktail hours; an occasional high tea; and chauffeur service.

One new development that has just begun to gain some steam in the past year is something called "Case Management" services. Although it has not yet made much headway in Ohio (Cleveland is the only known area where such services are available), it's a concept that is beginning to become more and more widespread.

Essentially, this kind of service makes available licensed or certified

Listed below are Ohio's area agencies on aging. If you have questions about services for elderly patients, and what may be available in your community, they would be good sources for you to turn to.

- **Council on Aging of the Cincinnati Area**
  601 Provident Bank Building
  Seventh and Vine
  Cincinnati, Ohio 45202
  William Bogart, Director
  513-721-1025

- **Area Agency on Aging**
  311 Building, Suite 201
  311 E. Market Street
  Lima, Ohio 45801
  Lewis McPeek, Director
  419-222-7723

- **Area Agency on Aging of Northwestern Ohio, Inc.**
  506 Madison, Suite 106
  Toledo, Ohio 45604
  Billie Sewell-Johnson, Director
  419-248-4234

- **District Five Area Agency on Aging**
  50 Blymyer Avenue
  P.O. Box 966
  Mansfield, Ohio 44901
  Caroline Ford, Director
  419-524-4144

- **Central Ohio Area Agency on Aging**
  272 South Gift Street
  Columbus, Ohio 43215
  Gerald Borin, Director
  614-222-7250

- **Area Agency on Aging, District 7, Inc.**
  P.O. Box 978
  (Rio Grande College)
  Rio Grande, Ohio 45674
  Robert Horrocks, Director
  614-245-5306

- **Greene County Commission on Aging**
  (As of press time, no office has been permanently located. Please refer calls to The Ohio Commission on Aging.)

- **The Ohio Commission on Aging**
  50 West Broad Street, Ninth Floor
  Columbus, Ohio 43215
  Joyce Chapple, Director
  614-466-5500

- **Buckeye Hills-Hocking Valley Regional Development District**
  Suite 410, St. Clair Bldg.
  216 Putnam Street
  Marietta, Ohio 45750
  Cindy Farson, Director
  614-374-9436

- **Area Agency on Aging, Region 9**
  Box 429
  117 S. 11th Street
  Cambridge, Ohio 43725
  Evelyn Brockwell, Director
  614-439-4478

- **Western Reserve Area Agency on Aging**
  Marion Building, Room 512
  1276 West Third Street
  Cleveland, Ohio 44113
  Elaine Woloshyn, Director
  216-443-7560

- **Area Office on Aging**
  12 East Exchange, 3rd Floor
  Akron, Ohio 44308
  Joseph Ruby, Director
  216-376-9172

- **District 11 Area Agency on Aging**
  112 W. Commerce Plaza
  Suite 303
  Youngstown, Ohio 44503
  Martha Murphy, Director
  216-746-2938

"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

* Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

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BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request. © 1982, Pfizer Inc.

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What do I do?

continued

social workers who, for a fee (usually $50 an hour) will step into a senior's home, assess the needs and provide referrals — whether it be for home nurses, geriatric physicians or attorneys. They also help clients process Medicaid and Medicare forms, and some will even go so far as to offer therapeutic counseling to distraught relatives — far and away the largest purchaser of these services.

With geographic displacement so commonplace today, the son or daughter who is attempting to be caretaker for an aging parent 3,000 miles away finds these services heaven-sent.

"This for-profit sector of health care is going to grow," says Rose Dobrof, director of the Brookdale Center on Aging of Hunter College. Dobrof was quoted in a recent issue of the *New York Times*.

One drawback to this service is the fact that it is currently unregulated, and unless patients seek professionals with proper certification, they may or may not receive the kind of help they need.

The other drawback is one Dobrof raises: "Many people cannot afford these services which should be available to all of us as a right" — a familiar argument.

Watch for this service in the future, though. The market seems ripe for it.

As more and more options make themselves available in the marketplace, you, the physician will more than likely find yourself weighing the pros and cons of each of these alternatives — not only for your patients, but with them. The New Elderly are a vocal lot — and they are no longer content to have their needs dictated to them. They want to participate in the decision-making, especially when it pertains to their health — but they will, no doubt, be looking to you as a source of information.

Featured with this story is a list of area agencies on aging, furnished by the Ohio Commission on Aging. Keep the list handy, because these agencies will be the ones with all the updated information on the types of health care which may be available in your area, both now and in the future. It's information you're going to need — maybe sooner than you think. **OSMA**

Karen S. Edwards is Executive Editor of the Ohio State Medical Journal.

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Benefits diuretics cannot offer... Once-daily INDERAL LA (propranolol HCl) provides smooth, 24-hour control of blood pressure plus the cardiovascular benefits of the world's leading beta blocker. And INDERAL LA provides a high degree of patient acceptance—without potassium problems.

Experience no other beta blocker can match... Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

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Just once each day for initial therapy in hypertension.



80 mg · 120 mg · 160 mg

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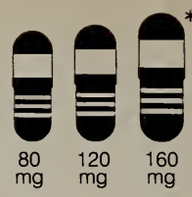
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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end-diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by a delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathogenic or functional changes, sympathetic activity is detrimental to the patient but there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 4 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Ohio Plans for the Care of its Elderly

By Karen S. Edwards

We've taken a look at what is presently available in terms of care for your elderly patient. But what about the future?

By the year 2000, an estimated 13.5 million people will become 75 years or older, and 3.2 million will turn 85 or older. What kind of care will be available then?

The question seems to be particularly applicable now that the Medicare system is experiencing difficulty. Before, the federal government was always there to promise health care to the country's seniors when the time came. Now, however, the federal government isn't making any promises, and, in fact, it's looking to the state governments to pick up the ball and keep it rolling . . . something of which Ohio is already well aware.

In a keynote speech, given last June before the Ohio Conference on Aging, Governor Richard F. Celeste said, "If we think about the impact of the federal government which has steadily reduced its financial support for many programs we provide for senior citizens, there is a tremendous challenge in the years ahead, and perhaps none greater than to ensure medical care which we can all afford for all our citizens in Ohio."

In talking, further, about health-care costs, and their impact on state government, the Governor also noted that Medicaid caused the state to spend $172 million in 1972; in 1982, the state spent $1.2 billion.

"If we continue to go as we are going, the State of Ohio will be spending one-third of all of its General Revenue Funds on health care costs by 1987," he said.

The State isn't the only one affected by the proposed changes in Medicare/Medicaid.

"All of us are left scrambling around, picking up the pieces," says Vicki Tripodi, a gerontology clinical nurse specialist at a Columbus hospital. "The federal grants that were around in the 1970s, for gerontological planning are gone, and now we learn that Medicare money is not going to be there either."

As a result, she says, a network is beginning to develop around the state, comprised of others, like herself, who are interested in geriatrics, and the fate of those in that ever-increasing population.

"Maybe it's because we baby boomers are beginning to think about our own future. In twenty years, we'll be dealing with aging parents. In forty years, we'll be experiencing the problem first-hand."

In any case, she says, the support won't be there like it has been in the past.

"There is a real feeling that we're all

in this together, so yes, there *is* a geriatric network developing. In a sense, we're all trying to help each other out."

Perhaps the one source to whom everyone is turning for answers is the Ohio Commission on Aging (OCA), a state-supported agency which provides both organization and funding for an assortment of area and community agencies on aging, as well as a variety of services and programs for the state's seniors.

And there is no doubt that OCA has been looking into the problem . . . long and hard.

"We have one immediate goal," says Joyce Chapple, a Toledo native who became the Agency's Executive Director last June," and that is to find ways of taking care of our elderly in the best, yet most cost-effective manner possible."

For those at the OCA, that means focusing attention on those services which can keep the elderly at home, and out of institutional settings.

"We're not saying that nursing homes are bad. We recognize that there is a genuine need for them, and that's fine. But what we are attempting to do right now is to prevent premature institutionalization of the elderly.

"I think that most experts would agree that maintaining an individual in his or her own home, if it's at all possible, is much more desirable than placing them in nursing homes — and it's much less expensive."

A project, working under the name "Passport" is the state's initial effort in this area. While it is still on the drawing boards, it is coming as close as any project of the OCA to becoming reality. " 'Passport' will be launched probably sometime this year under the auspices of the Ohio Department of Public Welfare," Chapple says.

"In effect, the project will be a sophisticated evaluation process. It will take a look at the state's elderly, specifically those who need constant care, but do not need to be in a nursing home. The project will examine existing support services in each community, and what services may need to be brought in to keep these kinds of patients out of nursing homes, and living independently at home."

If it is demonstrated that this kind of program works, that the elderly can be kept at home, and at a cost savings, it is likely that additional, larger appropriations will be made in the state budget, increasing the area of home health care.

"We need to stress, though, that the human aspect is our primary focus," Chappel says. "Cost is not the very bottom line."

To follow up on the idea of home health, Tripodi, the gerontology clinical nurse, is willing to predict that the existing area of adult day-care will be receiving more attention in the future.

"When health care professionals become aware of the total scope of services which are available to older Ohioans, I think we'll be seeing fewer people resorting to institutionalized care."

She, herself, is actively involved with an adult day care center in Columbus, and she holds high hopes for this field, despite its slow growth to date.

"This kind of idea takes a while to catch on," she explains. "It calls for a major change in lifestyle, which most people aren't used to making. After all, it involves a conscientious effort to go to your parent's home, get him or her dressed and delivered to the center. It needs to become a habit, the same way that getting children ready for pre-school has become a habit for a good many parents. The pre-school concept began slowly, too," she says.

Chapple agrees that the concept has potential.

"The idea has been around since 1977-1979, but it has been steadily growing as understanding of the concept has become more widespread. When health care professionals become aware of the total scope of services which are available to older Ohioans, I think we'll be seeing fewer people resorting to institutionalized care. And, I think too, we'll be seeing people helped who may not have received care in the past."

Another direction which the OCA is taking is in the area of housing.

"I'm something of a housing fanatic," Chapple admits, "But I think it's an area that is going to need more of our attention in the future."

The Commission is currently attempting to launch a "Shared Living" program, similar to the one which has achieved some degree of success in New York.

"Right now, we are making requests for grant proposals, and seeking out individuals and organizations who want to participate in the program," Chapple says.

Once the program is underway, it will involve finding a home-like setting for two or more older persons who can't live alone, but can provide support for each other.

"We want to examine other types of alternative housing arrangements," Chapple continues. "We want to be able to offer the state's elderly someplace besides nursing homes and independent living complexes."

She recognizes, too, that some degree of planning is also going to have to be directed to the state's ambulatory elderly.

"Seniors today are more active than they ever were. We need to provide them with more opportunities to get involved," she says.

One example she gives is participating in the construction and renovation of multi-purpose senior centers.

"There are twenty to thirty counties which don't have senior citizen centers in their communities," Chapple says, "and yet these centers offer so much. They often provide a noon meal, socialization, health screening, etc. We

need to develop more of these in the future."

She is interested in finding seniors who want to become involved in running and operating these centers as well.

"We need to expand employment opportunities, so that seniors can continue to work after retirement. Now, if they choose to do so, they are penalized by the Social Security system."

But that may not be for long.

"The elderly are becoming the fastest growing political force I've seen, today. When the U.S. House Select Committee on Aging recently held a hearing in Washington, it was standing room only. Busloads of seniors couldn't even get in the doors. They had come to testify on their own experience with medical services and medical costs. They are a very vocal, very active group, and becoming even more so. And, they're becoming better educated in terms of their health care. I think you'll find the elderly will be much more careful about the utilization of medical services in the future. The mid-eighties is certainly the time you'll be hearing from them."

Their activities are not necessarily confined to politics, either, she adds.

"I've seen more seniors at health spas than I've ever seen in the past," she says, adding that she's anxious to expand the scope of the state's Golden Buckeye card to include discounts at private recreational facilities and health clubs, and at large grocery store chains.

"We want to make the card more valuable," she says.

Because state issues two and three were defeated in the last election, Chapple is optimistic about getting the Commission's plans and projects off the ground.

"Our future moves will be in two directions," she says. "We will strive to provide critical services for the frail, and at the same time, strive to maintain services for the active seniors, as well as explore new ways to serve this group. Political leaders are aware of costs, and the need to cut them, but aging programs will need to become a high priority item."

As she explains, seniors are beset with problems that range from transportation to fixed income.

"There is a growing enthusiasm and energy on the part of our seniors. They are experiencing a quality of life not realized before. And these problems concern them. The high cost of health care concerns them. Our future programs will have to address these issues. We just can't ignore them.

"Physicians are important to this whole plan. They need to be aware of what the problems are, and make us aware of how best to handle them," Chapple says. "For our part, we can provide the physician with information on the resources available in his or her community — resources that can meet the needs of his or her elderly patient. It's a network that can work both ways."

"All of us are left scrambling around, picking up the pieces. The federal grants that were around in the 1970s are gone, and now we learn that Medicare money is not going to be there either."

Chapple feels confident that the Commission is making all the right moves to insure adequate care for the state's elderly — today, as well as ten, twenty, forty years down the road. Those moves seem to be in the direction of home care, and away from the high costs of institutionalized care.

Whether or not she is right is something that only time will tell as Ohio continues to come of age in the years ahead. **OSMA**

Karen S. Edwards is Executive Editor of the **Ohio State Medical Journal.**

Ohio State Medical Journal Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted *in the original* on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). *The entire text including lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACED with margins of at least one inch on all sides.*

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. *The Journal* will assume $10 of this expense and the author will be billed by *The Journal* for the remainder.

(b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.

(c). Legends for the figures should be written on separate paper.

(d). The author must affirm that he has *written releases* on all photographs in which patients can be identified.

5. **ABSTRACTS.** A *short* (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the *order of their appearance in the text.*

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's surname and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

"2. Doe J, Roe RX: How to go about it. Ohio State MJ 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: Modern Medicine, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

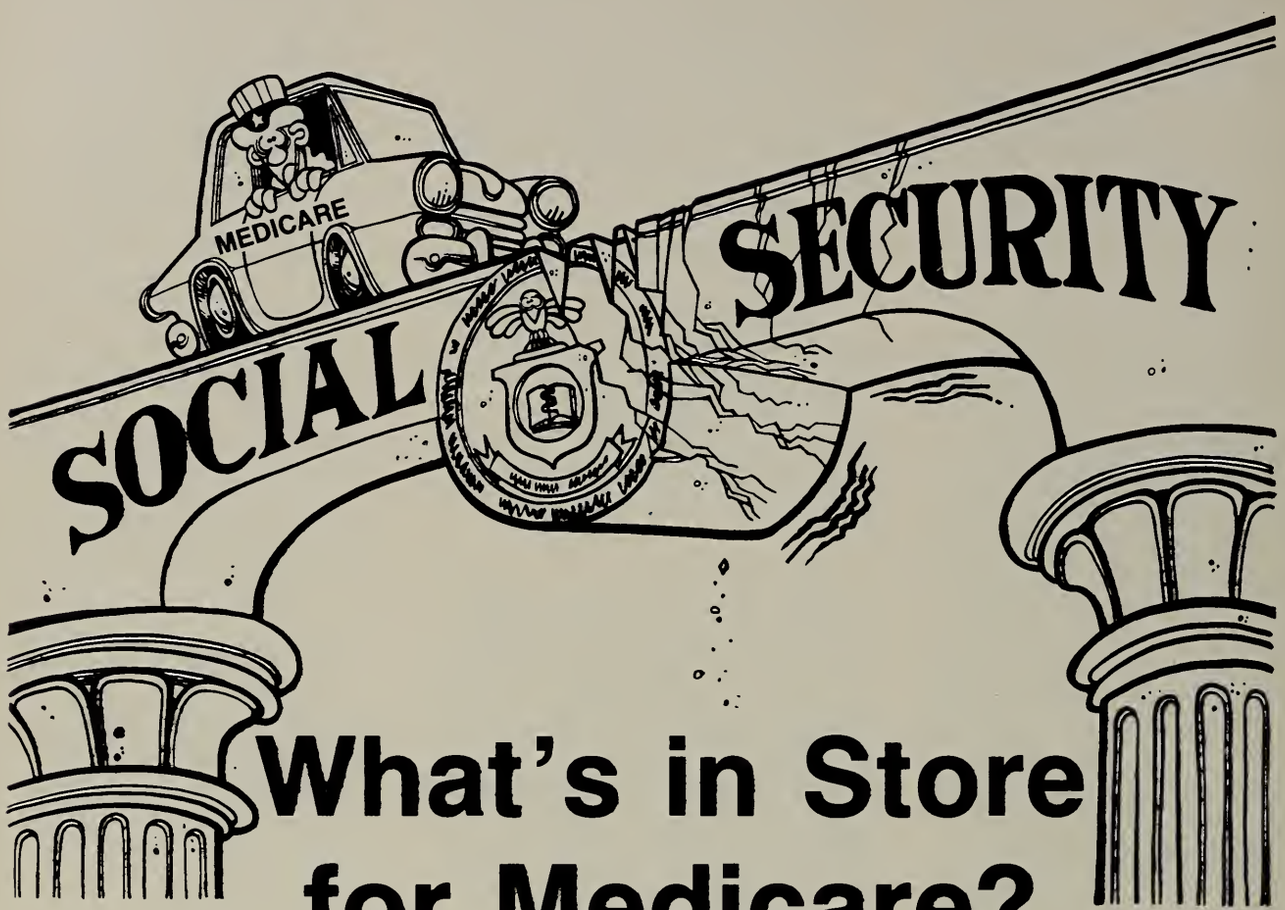
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What's in Store for Medicare?

By Susan Porter

When the Reagan Administration announced earlier this year that the Medicare program will be a major target of budget cuts in 1985, Paul S. Metzger, MD, was not surprised. Dr. Metzger, vice president and chief medical director for Nationwide Insurance Companies, which administers Part B Medicare payments in Ohio, has seen Medicare's demise coming for nearly two decades.

Today, 26 million older Americans and 3 million disabled persons under age 65 depend on Medicare to help pay their doctor and hospital bills. As a result, one out of every ten dollars in the federal budget goes into public health care programs, the fourth largest expenditure item in the budget after income security, national defense and interest on the public debt.

Perhaps the biggest reason the Medicare system is in a state of demise is the system itself.

In Ohio and West Virginia, alone, some 45,000 Medicare claims are processed each day, according to Dr. Metzger, a feat made possible only by the speed of computerization. Not even a computer, however, can come up with a way to balance a budget that continues to grow at a faster rate than the monies it takes in.

The cost of the Medicare program has risen dramatically since its first full year of implementation, 1967, when its total budget was $3 billion. In 1983, the program cost taxpayers $4.7 billion *per month.*

Current government projections indicate that if the program is not cut by 30% or income is not increased by 43% — or some combination of the two — the Medicare trust fund will run dry before 1990, leaving 95% of

the elderly in this country with no way to pay their health care bills.

"The AMA (American Medical Association) gave expert testimony back in 1965, pointing out exactly what was going to happen — the way the cost of the program would constantly increase because of how the program was structured," Dr. Metzger recalls. "But the politicians at that time saw an immediate need, and they responded to that need without looking down the road to see what might happen in the future."

A chronic condition

Part of the problem, Dr. Metzger points out, is the nation's growing population of elderly; some 1,000 additional Americans become eligible for Medicare each day. Over the next 40 years, as the "baby boom generation" matures into the "senior citizen explosion," the population of older Americans is expected to more than double to 58 million, while the population-at-large — including those taxpayers who must support programs like Medicare — will grow by only 30%.

The problem is compounded by the fact that older Americans use over three-and-a-half times the health care of persons under 65, and have nearly three times the number of chronic conditions as adults 56 to 64. According to a recent AMA report, the elderly, who make up only 11% of the population, accounted for 36.2% of the $255 billion spent on health care in 1981. That year, those aged 65 and over used $3,140 per capita, as compared to $828 per capita for persons under age 65.

But the problem goes beyond the aging population, the high proportion of health care used by the elderly, and even the fact that modern science and technology have rendered new and expensive treatments which have resulted in record-long lifespans — and subsequently longer Medicare rolls. Perhaps the biggest reason the Medicare system is in a state of demise, according to Dr. Metzger, is the system itself.

"From the beginning, Medicare was structured to encourage utilization of the system, and the system responded," he says. "Hospitals were reimbursed on a cost basis, so whatever the hospitals' costs, the system would reimburse. There was absolutely no incentive on the part of the hospital to economize; rather, the incentive was to expand."

Relatively low deductibles and copayments encouraged patients, also, to get the most out of the system by using health care frequently, Dr. Metzger points out. And because physicians were reimbursed for inpatient services on a per diem basis, the incentive was to keep patients hospitalized as long as possible.

With the implementation of the Diagnostic Related Group (DRG) prospective reimbursement system last October, much of this has changed, Dr. Metzger points out. Hospitals — now reimbursed a set amount of money for each patient according to the diagnosis, regardless of their costs — are motivated to keep expenditures to a minimum by treating patients as quickly and efficiently as possible. They are encouraging their physicians to do likewise, so the impetus now is to treat the patient on an outpatient basis whenever possible, Dr. Metzger says.

The most likely and immediate target of Medicare budget cuts is the health care system, with freezes on Medicare payments to both hospitals and physicians at the forefront.

Physicians' fees for services rendered both in and out of hospitals are not directly affected by DRGs, although physician DRGs for inpatient care is likely to be the next step in a long series of changes in store for doctors working with Medicare patients, he warns. Similarly, a freeze on physician fees for outpatient care and mandatory assignment are issues under current debate that could be implemented as part of a massive restructuring of the Medicare program next year.

Shifting the Burden

As of the *OSMA Journal's* press time, specific federal budget cuts and changes to the Medicare system had not yet been announced, although they were expected to highlight February budget talks between the President and Congress. Nearly all of the proposals shift the financial burden of health care for the elderly off the back of the federal government and onto the shoulders of the taxpayers, doctors, hospitals and the elderly, themselves.

Among the more controversial suggestions were those aimed at taxpayers-at-large: taxing a portion of employer-paid health insurance benefits and increasing excise taxes on alcohol and tobacco. Neither was expected to be popular with either the President or Congress during this election year, although chances are these suggestions will resurface in 1985.

Other proposals would shift more of the cost of health care to the elderly: increasing coverage premiums from $146 to $246 a year; increasing copayments and deductibles by substantial amounts; limiting coverage but including catastrophic illnesses, and raising the eligibility age from 65 to 67. These also were expected to bring a great deal of protest, particularly from senior citizen groups now actively lobbying for health care rights (see related story).

Thus, the most likely and immediate target of Medicare budget cuts is the health care system, itself, with freezes on Medicare payments to both hospitals and physicians at the forefront.

Freezing fees and mandatory assignment

Historically, physicians have enjoyed the freedom of setting their

continued on page 201

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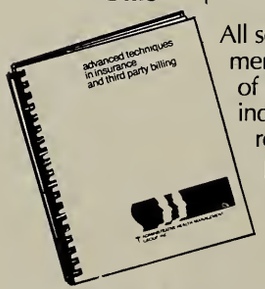
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own fees — according to what they feel their services are worth — and then billing their patients directly for those services rendered, says Dr. Metzger. However, with a greater and greater share of doctor bills now covered by third-party payers — including the Medicare system — that practice is changing, although, to date, the freedom remains intact.

Two proposals already being debated in Washington could change the method of reimbursement. Currently, "customary" and "prevailing" fees paid physicians through Medicare are refigured periodically, says Dr. Metzger, although they generally are several years outdated, which is one reason many physicians refuse to accept them in-full for their services. In order to keep the cost of Medicare from rising, Congress might choose to "freeze" those figures at their current levels, meaning the gap between physicians' fees and Medicare reimbursement will increasingly widen.

In addition, there is a proposal before the U.S. House of Representatives to force physicians to accept assignment, taking away their freedom to bill Medicare patients directly for their services and thus to recoup the entire fee. Should this occur, many argue, the elderly in this country will suffer even more, as fewer physicians accept Medicare patients due to the inequity of the reimbursement system.

However, Dr. Metzger feels this is not necessarily the case. "That might have happened a couple years ago," he says. "But today I'm seeing too many physicians with holes in their schedules who could not afford *not* to take Medicare patients."

Alternatives to Medicare?

All of the above proposals, including those calling for additional taxes, larger copayments and deductibles, changes in eligibility, freezing payments to doctors and hospitals, and mandatory assignment could bring temporary relief to Medicare's symptoms. That they will render a complete cure, however, is debatable, and some continue to question whether the program deserves to live at all.

One Missouri congressman, for instance, has proposed that the system be eliminated and replaced with a voucher system. Elderly citizens would be given a voucher for a set amount of dollars to go out into the open market and buy a health care policy, join an HMO, or whatever they choose.

Dr. Metzger believes the plan might be a good one, because "it makes the individual more responsible" and it would "put the onus on the system (private insurance company, HMO, etc.) to manage it well." It also would allow the federal government to allocate "a predictable amount of money" for the program, and thus to control the amount it is spending on health care. Not surprisingly, the proposal is not "politically popular" among the insurance companies or the elderly, but it may gain some support in congress after the elections.

The Medicare system is chronically ill, and regardless of government leadership, some changes must take place if Medicare is to survive the decade and the nation's elderly are to receive care.

Another possibility would be the establishment of a kind of Preferred Provider Organization between the government and those in the health care industry. For instance, "Nationwide (Insurance), as a carrier, could establish a Medicare fee schedule and say to all physicians in Ohio, here it is. If you don't like it, you can opt out," Dr. Metzger explains.

Another possibility is the establishment of a "gate keeping" system. Elderly patients could be assigned physicians who would then be responsible for overseeing their total care — and who would have to approve all nonemergency treatment outside their offices, in order for a patient to be covered.

Perhaps the most dramatic alternative to the present Medicare system would be a "capitation" program — physicians would be paid a set amount of money for each elderly patient under their care, regardless of the treatment provided. While this kind of system, used in many European countries, "works well from a cost-effectiveness standpoint," says Dr. Metzger, "the quality of care is another story," because the incentive is to provide the patient as little care as possible.

While the prospects are frightening — particularly to those who hold fast to the principle that equal access to quality health care is the right of all human beings, regardless of their ages, regardless of the cost — the facts remain. The Medicare system is chronically ill, and regardless of government leadership, some changes must take place if Medicare is to survive the decade and the nation's elderly are to receive care.

Unless the November election brings a major change in administration, says Dr. Metzger, it is not likely that today's Medicare program will be left to die for a new nationalized system of health care, like that which was averted in the early 1960s when the Medicare program was born. If a new President is elected — then that is another story.

In either case, it is most likely that a combination of treatments will have to be prescribed to save the program. And no one is likely to be exempt from paying the bill. **OSMA**

Susan Porter is Assistant Editor of the Ohio State Medical Journal.

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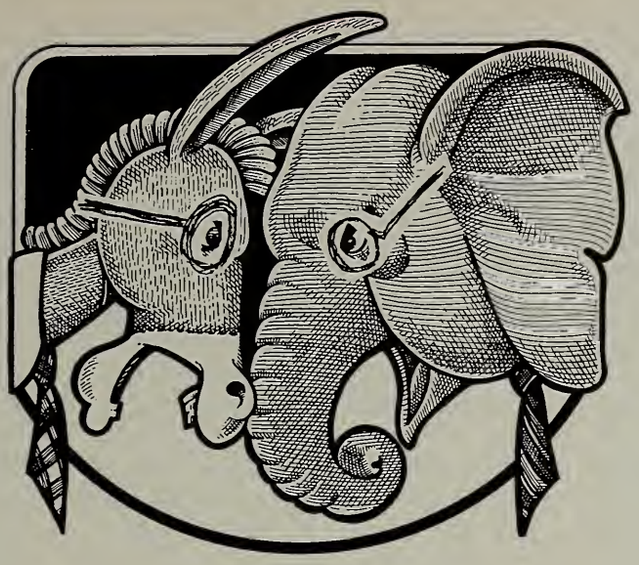
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The Voice of America Is Coming of Age

By Susan Porter

In the past, they've been viewed as feeble, dysfunctional and confused; their opinions eccentric and unimportant. They've been put aside in nursing homes, senior citizen villages, retirement centers — frequently far from family and friends — where they've been left to rock and reminisce about the "good old days." Often seen as a bother, but rarely as a threat, senior citizens have been one of the least vocal, least heard, least recognized minorities in the United States.

Until now.

Today — perhaps for the first time in history — older Americans are rising up out of their rocking chairs and into the halls of local, state and federal government in record numbers, reclaiming a voice in a system they helped to create but no longer control.

"We, who are supposedly retiring to 'the golden years' — which they are not — are very much legislatively oriented," says Dorothy Ryan, president of the Ohio State Council of Senior Citizens (OSCSC) which represents 136 affiliated senior citizen groups and organizations around the state. "Many of us have had to come back to work, just to save our programs."

The council is one of numerous coalitions springing up around the state and country working to give senior citizens a stronger voice — and one loud enough to attract the attention of policymakers and legislators. One of the areas they are shouting about the loudest is health care.

"It is critical that physicians understand the significant power of senior citizen groups and the increasing political power they will have as they continue to become better organized."

Each spring, the OSCSC holds an annual meeting to determine important issues facing older Americans and the direction or stands it will be taking over the coming year. This year, Ryan predicts, "We will be going tooth and nail after health care."

And more than likely, they will be heard; for just as senior citizens are joining together to form a collective voice, representatives in Washington and Columbus are listening to this rapidly growing group of voters with an open ear.

Senior citizen groups are becoming an active political force for a number of reasons, says Brent Mulgrew, Esq., associate executive director and staff counsel to the Ohio State Medical Association. Many of their members have the time — and are willing to spend the time — working on candidates' political campaigns, and "often that kind of quality time is more important than financial contributions," Mulgrew says.

Another factor, says Mulgrew, who frequently lobbies for the OSMA in Washington, is that "our population is aging rapidly. Those currently

showing the most interest in senior citizen issues are those now turning 65. But those who will be turning 65 ten years from now are growing even more concerned. And they are willing to exercise their political clout now — *before* they become senior citizens."

Just as the senior population is growing, so is the list of special interest groups who are organizing to fight for senior citizen rights. According to the Ohio Commission on Aging, over 50 organizations in the state keep regular tabs on issues involving seniors. They range from organizations like the Gray Panthers and the OSCSC to numerous retirement groups, church groups and labor organizations.

One of the most vocal is the American Association of Retired Persons (AARP) which has some 15 million members nationwide. According to Paul Smith, the new state director of AARP, 360 chapters exist in Ohio and a major concern among these groups is, "What's going to happen to Social Security and Medicare after the election?"

Already the organization is gearing up to address health care issues as they come before state and federal government. The "Living Will" bill and "Mandatory Assignment" of Medicare patients already have brought testimony from this organization and more is expected. Proposed Medicare cuts — and the fear that it is the elderly who will bear the brunt of those cuts — are likely to be the chief area of concentration for the AARP and its members in 1984.

"You have to keep in mind that there's a rumor going around that the old people have it made with government programs, and all," says Smith, "that the elderly have got to start bearing responsibility for the operation of Medicare. The fact is, there's a great den of poverty-stricken people who can't afford to be sick — and who already have been greatly hurt by Medicare and Medicaid cuts."

AARP, which acts as an advocacy group for all elderly, also incorporates members of the Retired Teachers Association within its organization. "I was a teacher in Ohio, and with my pension, I live a relatively comfortable life," says Smith. "Fortunately, my wife and I have not been sick. But we have close friends who have, and their medical bills for one year ran over $23,000. Only about $800 of that came out of their pockets, thanks to Medicare. But I've seen cases where families have been wiped out, stripped of everything they own because of a brain tumor, cancer, Alzheimer's disease. A lot of elderly people are terrified of getting sick."

Much of the fear, Smith admits, comes from a lack of understanding of what Medicare covers and confusion over the reimbursement forms that must be filled out. Thus, senior citizens are easy victims of overzealous insurance salesmen who want to ease their minds with various "medigap" policies which will pay the difference between what Medicare pays and what the patient owes.

"There's a real need for people to get together and start talking. It isn't all the old people's fault; and it isn't all the doctor's fault or the hospital's fault. If you want good services and treatment, you have to pay for them."

"We had one woman come to our AARP insurance counselor with six different hospital insurance policies, and she was paying each month on all of them," says Smith. "She couldn't keep up with the premiums, but she was terrified to let them go. She was afraid she might break a hip or have a stroke and there would be no one to take care of her."

For this reason, AARP is sponsoring a new program in several Ohio cities which provides free counseling to the elderly in filling out their Medicare forms and reviewing insurance policies. Volunteer senior citizens receive special training and then locate themselves for several hours a week in local senior citizen centers and retirement villages.

But AARP's Health Advocacy Services program is interested in more than just Medicare counseling, says Al Boffo, state coordinator of the program here. It also sponsors health education and information programs, is organizing a speakers bureau, and in one state, Florida, is piloting a "health care cost-containment project."

"To increase consumer awareness and involvement in health cost-containment, a statewide volunteer committee of older adults coordinates local groups to undertake community cost-containment projects, such as surveying the availability and cost of health services, compiling a list of physicians who accept Medicare assignment and sponsoring workshops on a variety of health topics," according to a description of the project which appeared recently in an AARP newsletter.

Most of the efforts of senior groups, however, are aimed directly at the White House — where their voices will be most heard and will have the most impact, particularly where issues like Medicare and Medicaid are involved.

"These people have strong beliefs in what they have been promised and what they feel they deserve, and they're willing to exercise their political power for it," Mulgrew says.

In the past, he points out, senior groups became active — and won — the fight for generic drugs. "It is critical, therefore, that physicians understand the significant power of senior citizen groups and the increasing political power they will have as they continue to become better organized," he says.

And while it is likely that seniors and doctors may speak on opposite sides of issues like freezing physician and hospital fees and mandatory assignment, it is equally important that both groups realize they have more in common and at stake than they may realize.

"Physicians will continue to talk about quality, when everyone else is

talking about dollars," says Mulgrew. "The public talks dollars when it doesn't concern them personally — they talk quality and access when it does. It's easy to talk about limiting dollars spent on kidney disease, until it's your dad — *or you* — who is going to push it over the limit."

Because senior citizens, as a group, are the biggest users of health care in this country, it is inevitable that they also will be fighting for quality and access when Medicare revisions are brought to the floor. "Physicians have always been in the forefront of that fight," says Mulgrew. "It will be crucial for us to join *with* senior citizens and other concerned parties to force the state and federal legislators to understand the importance of providing the funds needed to provide adequate care."

AARP's Paul Smith agrees. "There's a real need for people to get together and start talking about these things," he says. "It isn't all the old people's fault; and it isn't all the doctors' fault or the hospitals' fault, either. If you want good services and treatment, you have to pay for them."

Perhaps the key issue, says Mulgrew, and the question that will have to be answered by public and policymakers alike before the Medicare problem can be addressed, is "What is the public willing to spend on health care for its elderly citizens — for all of its citizens?"

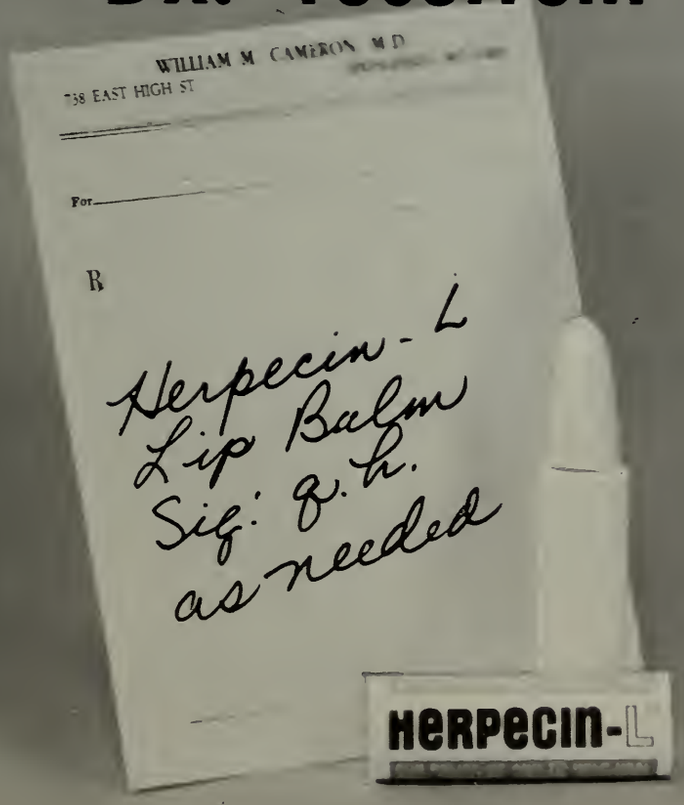
Smith points to an even larger sociological issue at stake. "It used to be that children took care of their older parents. Now the old people have become a drag, so the government is taking care of us. Somewhere along the line, we have to start facing up to this business. The dignity of every individual is involved." **OSMA**

Susan Porter is Assistant Editor of the Ohio State Medical Journal.

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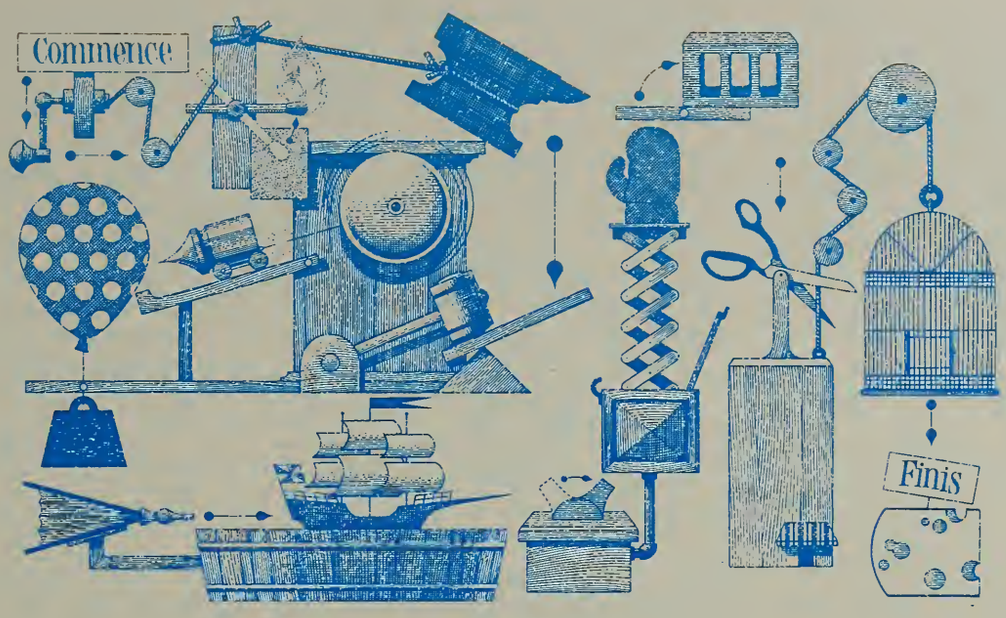
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A Better Mousetrap

95 Ways to Market Your Practice

By Carol Wright Mullinax

Admit it. You are either (a) very uncomfortable, (b) moderately uncomfortable, or (c) a little uncomfortable with the concept of physician marketing. Most physicians are. A dividing line, if it exists, seems to fall along age lines. Younger physicians appear to be more at ease with the idea.

The following story is a perfect illustration of that point: A father-son OB/GYN team was experiencing a slight decrease in number of patients. The son, fresh out of his residency, decided the answer was a little marketing. He wanted their patients to feel they were very special (and to pass the word along to their friends) so he purchased a case of music boxes at a discount and, as he made his rounds the day after delivery, he presented each patient with a music box, as a token of his and his father's esteem, and told her how much they had enjoyed working with her during her pregnancy. His plan worked. To a person, each mother was pleased with the physicians' thoughtfulness and concern. The father, however, was a little uncomfortable with the whole idea. As he encountered the pleased and thankful mothers on his rounds, he said, "Oh yes, my son got a deal on those music boxes. He had some notion about giving them out to patients so they will like us."

There are several morals to this story. One is: When marketing, at

least get your stories straight. Another is: Physicians may need to come to terms with the idea of physician marketing before they are any good at it. Many physicians are still haunted by the idea that marketing is tasteless huckstering and, therefore, beneath the dignity of a good physician. The feeling persists that a really good physician will not have to "resort" to marketing since their services should sell themselves.

These physicians need to wake up and smell the coffee, according to an AMA workshop entitled "Marketing Strategies for Private Practice."

New surveys indicate that less than half of the physicians in the nation are experiencing an increasing patient load. Under the twin binds of a physician surplus (only in some areas, yes, but still something that must be dealt with) and increasing competition from a variety of sources (HMOs, Urgent Care Centers, PPOs, etc.), physicians must take a long, hard look at their attitudes toward marketing.

The seminar begins with a look at a textbook definition of marketing: An ongoing process of finding out what the public (patient) wants and then matching your services to fit those needs.

Obviously, patients benefit from marketing because they get their needs (real or perceived) met. Physicians benefit because those satisfied patients tell, on the average, five other people how pleased they are (a dissatisfied patient, on the other hand, tells ten others). This is important since 43% of the people still choose their physician on the basis of recommendations of friends or neighbors. Another 26% base their decision on the physician's manner and personality. That's why patient relations play such an important role in any marketing plan. The AMA divides its marketing plan into six areas: availability to patients, patient relations, expansion of services, promotion, pricing and referral.

While it is true that no marketing plan should be undertaken without a thorough analysis of the practice itself, the community and the physician's wants and needs, here's a brief overview of the AMA's plan, along with specific tips you can utilize in your practice.



Availability To Patients

Convenience is the byword for patients. If you aren't available, the patient may turn to someone else who is. The following suggestions could improve your availability:

1.) Institute non-traditional office hours such as evening hours, early morning hours and weekend hours.

2.) Improve your availability by telephone. Arrange with a phone company to have a free peak load study or busy signal study done in order to estimate your equipment and staffing needs. Patients do not like to get busy signals when calling a physician's office.

3.) Establish definite callback periods in your schedule.

4.) Install a toll-free 800 number if you have many patients outside your immediate area.

5.) Consider making your home phone number available to your patients.

6.) Establish "call in" hours during which patients can speak immediately to you or your nurse.

7.) Make house calls. Nearly one-third of the physicians in the nation now make house calls. Let selected patients (the elderly or infirm) know of your availability for home visits.

8.) Redesign your facilities to provide easier access to wheelchair patients, infirm patients, etc.

9.) Locate your office in or near a shopping center. You may not only be more accessible to your regular patients, but available to serve the needs of shopping center employees as well.

10.) Use a patient beeper system. If you are within easy walking distance of a shopping area, allow patients to shop in the event of unavoidable delay and recall them to your office through a beeper system.

11.) Use referral services.

12.) Let your patients know you are available for after-hours emergency care.

13.) Improve your appointment system to minimize patient's waiting time.

14.) Provide transportation services for the elderly.

15.) Open a satellite office in an underserved area. Make certain, however, that you research such a project carefully before proceeding to be sure that it will be cost-effective. In smaller practices, once increased overhead costs and travel times are taken into consideration, satellite offices are often not cost effective.

16.) Reschedule follow-up visits. Don't just tell a patient to call for an appointment in six months and assume he or she will.

17.) Send reminders for annual health care visits. A reminder network can be set up that is coordinated with the patient's birthday so that he or she receives a combination birthday card/reminder notice.

18.) Provide child care services. Incorporate babysitting or day care services into your practice, or locate in an area where such services are readily available.



Patient Relations

Being a "good" doctor is not enough, especially if you want patients to be enthusiastic enough to

recommend your services to others. Patients want to know you care about them as well as care for them. Here are some things you can do to improve patient relations.

19.) Send a welcome letter to a patient after the initial appointment has been made. Thank the patient and enclose a patient information handbook (available from OSMA).

20.) Instruct staff to handle all phone calls courteously and promptly.

21.) Acknowledge patients immediately upon arrival.

22.) Address a patient by name whenever possible. Be very sensitive to patients' feelings in deciding whether to use formal or informal terms of address.

23.) Explain all lengthy delays, and make sure that patients are given the opportunity to reschedule if they so desire.

24.) Provide interesting, up-to-date reading material for your patients. In some instances, provide a television set (with the volume controlled). Many patients might appreciate a copy of the daily paper. Parents often appreciate comic books or children's literature for their youngsters.

25.) Provide refreshments — coffee, juice, etc.

26.) Provide educational materials; Many forms are available — write your own educational materials, produce your own video or audio cassettes, establish an office library, etc. (Synergy is available from the OSMA.)

27.) Provide a telephone for your patients' use either in your reception area or in adjoining hallway.

28.) Ask about the patient's family. Some physicians jot down personal notes about each patient and keep them in the patient's chart. A few physicians even have photographs taken of each patient and attach them to charts to refresh their memory.

29.) Spend adequate time with each patient. Surveys indicate that patient satisfaction is directly correlated with the amount of time the physician spends with the patient.

30.) Answer patients' questions. The basic questions that must be answered are, what is wrong with me? What caused it? What are you and I going to do about it? How long is it going to take? How much is it going to cost? What effect will it have on activities?

31.) Maintain eye contact with your patients while you are talking to them.

32.) Never interrupt or contradict a patient's objections. Instead, listen, restate, paraphrase and explain.

33.) Explain the necessity of all lab tests and x-ray examinations which you order, and the billing procedures for such examinations.

34.) Inform patients about what happens after they leave. Let them know what you will be doing for them before their next visit, and that you will follow the progress of their cases.

35.) Walk patients to the door, or in some other way bring your encounter with the patient to a cordial conclusion.

36.) If you are in a group practice, put pictures of all group members in the waiting room so patients can become familiar with all the physicians.

37.) Put a bulletin board in the waiting room for news about patients, physicians, staff.

38.) Put a suggestion box in your office or conduct a patient survey (available from the OSMA).

After a patient has visited your office there are many things that can be done to insure good will. This list includes the following:

39.) Call patients a few days after their visits to see how they are doing, when appropriate. Most patients will greatly appreciate your concern.

40.) Call with good lab results. Patients appreciate knowing all is well.

41.) Send holiday cards, birthday cards, etc.

42.) Send flowers to a new mother, or treat the new parents to dinner.

43.) Stamp "thank you" on all patients' cancelled checks.

44.) Conduct classes for small numbers of your patients with the same condition.



Expansion of Services

If you want to expand your practice, you must identify a group of patients with specific needs or desires, and then design new services or expand existing services to meet those needs. Some suggestions are:

45.) Buy other practices. Consider buying the practices of physicians in your area who are moving or retiring.

46.) Enter into contracts. Take opportunities to enter into appropriate service contracts to deliver care.

47.) Institute a full-time emergency care program. This will necessitate that at least one health care professional be available around the clock.

48.) Open a primary care satellite or a convenience clinic. This is most appropriate for multispecialty or hospital-based physician groups.

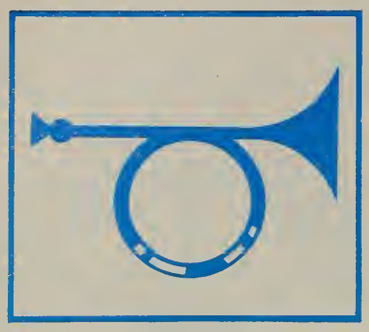
49.) Do in-office outpatient surgery. Expand the facilities, equipment and staff within your office to enable you to do recognized in-office surgical procedures.

50.) Establish a comprehensive fitness or exercise program to complement your other services.

51.) Establish a wellness program.

52.) Provide sports medicine services.

continued on next page



Promotion

No matter how good you are, patients can't choose you as their physician if they don't know you exist. Here are a few tips on promotion:

53.) Become active in your community — join your local medical groups, volunteer to serve on medical society committees, join worthwhile community groups.

54.) Get to know respected community members, especially pharmacists and members of the clergy. They get many requests for the names of good physicians.

55.) Do volunteer work. Volunteer for emergency room rotation, or for work in nursing homes, hospices, etc.

56.) Use your interests to your advantage. Become affilated with groups which share your hobbies and enthusiasms, and whose members may have a particular reason for seeking medical care from a fellow member.

57.) Become involved in your local schools — participate in career nights, sponsor scholarships, serve as a team physician, buy space in the school yearbook, etc.

58.) Volunteer to speak before community groups, school groups, neighborhood associations (OSMA sponsors a Speaker's Bureau).

59.) Give free health screenings at community centers.

60.) Sponsor or participate in a "health fair."

61.) Prepare a patient information handbook and distribute it effectively (available from the OSMA).

62.) Develop a patient newsletter.

63.) Develop a logo for your practice and put it on everything — office stationery, invoices, business cards, handbooks, doors, etc.

64.) Dispense small health-related items which patients can take with them as a gift from your office.

65.) List yourself in the Yellow Pages.

66.) Carry business cards with your practice's name, address and phone number. Such cards should always be available to anyone you encounter. Also, give cards to nurses and assistants, who occasionally are asked who they work for.

67.) Write letters to the editor of the local newspaper on topical issues on which you are competent to speak.

68.) Know your target markets. If you provide services that would be appealing to a particular group (senior citizens or non-English speaking groups, for example) let community groups which represent or deal with those groups know about your services.



Pricing

Perceived "high" fees continue to be a source of dissatisfaction for patients. The following are some options you might want to consider to help your patients understand and deal with your fees.

69.) Price yourself effectively. Choose a pricing strategy that is not only fiscally sound but also sensitive to the financial needs of your patients.

70.) Examine the local pricing environment, especially as it is influenced by government, business and third party payer policies.

71.) Develop credit policies; put them in writing and make sure your patients know about the policies.

72.) Always be willing to discuss and explain your fees.

73.) Have a written fee schedule available for patients upon request.

74.) Request payment at time of service for moderate medical charges, and educate patients as to how this will cut costs for them.

75.) Offer discounts to patients for payment at the time of service.

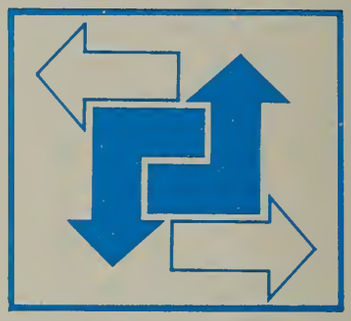
76.) Donate services to unemployed or indigent patients, either as an individual or as part of a program sponsored by the local medical community.

77.) Accept credit cards (OSMA offers a credit card discount plan).

78.) Offer inducements of free or discounted services to introduce patients to your practice.

79.) Help patients understand their insurance policies — what will and won't be covered — before service is rendered.

80.) Help patients file insurance; this is a real service to your patients. And it assures you that the forms will be filled out correctly.



Referrals

Referrals are an important source of patients and income for physicians. The following are ideas on how to increase referrals from your colleagues.

81.) Develop a written information sheet for the physicians who refer to you. Detail the goals, policies and procedures by which you handle referral patients, and list the various services you offer to referring physicians.

82.) Try to be as accommodating as possible in meeting the needs of both the referring physician and the patient by seeing the patient promptly.

83.) Install a private telephone line in your office that is connected to a recording device. Inform referring physicians of this private number and invite them to dictate consultation requests or patient information at their convenience.

84.) Do your best to return patients to the referring physician. Do not steal patients. If a referred patient chooses to remain under your care, discuss the situation with the referring physician as honestly and tactfully as possible.

85.) Always report back promptly

to a referring physician.

86.) Do not belittle the treatment the patient has received from the referring physician. Any disagreements about treatment should be resolved with the referring physician.

87.) Do not overcharge for your services. Complaints and resentments about excessive fees will be directed not only at you, but at the referring physician as well.

88.) Contact a consultant in a personal manner and with respect. Writing an order and letting the nurse make the call is not sufficient.

89.) When initiating a call to a consultant, be on the line. Do not keep the other physician waiting; this is sure to cause resentment.

90.) Be sure you make the distinction between a consultation and a referral. If you wish the patient back, make sure the consulting physician knows that you are referring the problem and not the patient.

91.) Don't wait until the last minute to refer patients. Give the consultant time to study the patient's history.

92.) Tell the patient why he is being referred. Make sure the patient acquiesces to your choice of consultant.

93.) Don't dump troublesome patients on consultants just to get rid of them.

94.) Some consultants may appreciate a report on the final disposition of a case in which they played a part. If so, provide this report.

95.) Keep track of all referred patients. **OSMA**

Carol Wright Mullinax is Associate Director, OSMA Department of Communications.

May Meeting Planned

CURRENT TOPICS IN CLINICAL MICROBIOLOGY: May 9-10; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: $150, $100 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

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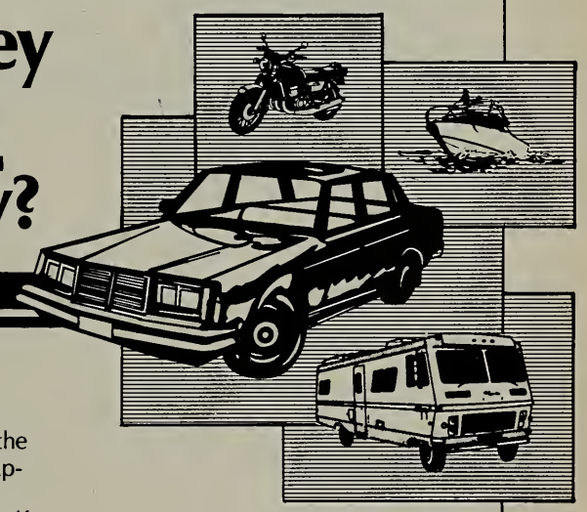


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State Medical Board Revises Laboratory Testing Policy Paper

By D. Brent Mulgrew, JD, and Catherine C. Costello, JD

At the request of the Northern Ohio Chapter of the American College of Certified Nurse Midwives, the State Medical Board has reconsidered its September 14, 1983 position paper regarding the ordering of laboratory tests by certified nurse midwives (see p. 871 of the November, 1983 issue of the *Journal* for related story).

The Board has amended its position as follows:

"Section 4731.33, Ohio Revised Code, concerns the conditions authorizing the practice of midwifery and states as follows:

"A holder of a certificate to practice midwifery at all times shall practice midwifery under the direction and supervision of a doctor of medicine or doctor of osteopathic medicine and surgery holding a license to practice medicine or surgery issued pursuant to Chapter 4731. of the Revised Code.

"No certificate to practice midwifery shall authorize its holder to perform version, treat breech or face presentation, do any obstetric operation requiring instruments, or treat any other abnormal condition, except in emergencies.

"Hence, the certified nurse midwife, under supervision, provides care to women with normal *obstetrical prospectus in the antepartum, intrapartum, and postpartum periods.*

"Recognizing that the certified nurse midwife can only function under the direction and supervision of a physician, it is the Board's position that laboratory tests for obstetrical patients should be ordered by such physician, unless otherwise permitted or required by Ohio statutes. A physician's order may be contained in a formal protocol signed by the physician; however, the physician's name should appear on the laboratory request.

"Finally the interpretation of laboratory tests is solely the function of the physician. Interpretation of tests constitutes diagnosis, and is, therefore, the practice of medicine." ***Position paper of the state medical board as amended 1-11-84.***

The Board's updated position no longer requires that a physician sign each laboratory request slip for a patient seen by a certified nurse midwife. Instead, the supervising physician's name must appear on the request slip which is submitted to the laboratory. While the results may be returned to the nurse midwife, only the physician can interpret the results.

The significance of the Medical Board's action lies in the recognition that a certified nurse midwife can operate under a standing protocol developed in conjunction with her supervising physician. The ordering of routine laboratory tests may be included in the standing protocol.

The Board's action came after a certified nurse midwife appeared before the Board and explained her practice and procedure. The Medical Board discussed in detail the nature of the standing orders used by this nurse midwife. The procedure which the Board recognized as acceptable was one in which: 1) the certified nurse midwife only orders *routine* laboratory tests during the first prenatal visit; and 2) the certified nurse midwife does not see the patient again until the supervising physician has seen the patient. The physician makes the determination whether the woman is a suitable candidate for obstetrical management by the certified nurse midwife (i.e., whether the patient is a normal obstetrical case).

The Board did not address the issue of whether other types of standing protocol would be recognized as acceptable forms of supervision for purposes of Section 4731.33 of the Ohio Revised Code. **OSMA**

The OSMA is registered as a 501 (c)(6) corporation with the Internal Revenue Service. To maintain such standing, the Association's activities must promote the common interest of the membership rather than provide specialized services to individuals. Consequently, this column will be devoted to general legal questions of interest to the membership. Suggestions for future columns may be sent to: OSMA Department of Legal Affairs.

D. Brent Mulgrew, JD, and Catherine Costello, JD, are in OSMA's Department of Legal Services and serve as OSMA's Staff Counsel.

Third Party Problems?

For help contact:

OSMA Department of Government Relations

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Council Proceedings

December 10, 1983

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, December 10, 1983, at the OSMA Headquarters' Office, Columbus, Ohio.

Those present were: S. Baird Pfahl, Jr., M.D., Sandusky; A. Burton Payne, M.D., Ironton; C. Douglass Ford, M.D., Toledo; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Thomas R. Leech, M.D., Lima; Benjamin H. Reed, M.D., Wauseon; Donavin A. Baumgartner, Jr., M.D., Cleveland; J. James Anderson, M.D., Youngstown; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; D. James Hickson, M.D., Mt. Gilead; D. Ross Irons, M.D., Bellevue; Joseph L. Kloss, M.D., Akron; James E. Pohlman, Esq., OSMA Legal Counsel, Columbus; Oscar W. Clarke, M.D., Chairman, Ohio Delegation to the AMA, Gallipolis; Stella Brown, President, OSMA Auxiliary, Dayton; Don Goodwin, Senior Vice President, PICO, Pickerington; David L. Jackson, M.D., Director, Ohio Department of Health, Columbus.

Those present from the OSMA Staff were: Hart F. Page, CAE; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew, Esq.; Rebecca J. Doll; Gail E. Dodson; Robert E. Holcomb; David C. Torrens; Carol W. Mullinax; Eric L. Burkland; Michael L. Bateson; Catherine M. Costello, Esq.; Louis N. Saslaw; William E. Fry; Aristotle Hutras; Vickey McVay; Carol Maddy.

President Pfahl congratulated Deputy Executive Director Gillen on the anniversary of his twentieth year with the Ohio State Medical Association.

Administration

Executive Directors Report

Mr. Page announced that the OSMA Travel Program had more than twice the participation in 1983 over 1982. He commended the cooperating county medical societies, The Toledo Academy of Medicine and Columbus Academy of Medicine for their role in the program.

PACO

Dr. Abromowitz presented the report of PACO, indicating vigorous growth with results well above the business plan projections.

Council Minutes, November 12-13

President Pfahl reviewed the minutes of the Proceedings of the Council Meeting of November 12-13. It was moved and seconded to reconsider the proposed submission to the House of Delegates of a $65 dues increase in 1985; $25 in 1986, and $20 in 1987. The motion prevailed. It was then moved and seconded to submit a dues increase of $55 in 1985; $25 in 1986, and $20 in 1987. After discussion, the motion *was approved*, with one dissenting vote (Dr. Reed).

Financial and Membership Department

Membership Statistics

Mrs. Wisse reported an OSMA membership gain of 1,126 over the previous year.

Treasurer's Report

Dr. Barr reviewed the Treasurer's Report, which was presented in writing. It was filed.

Department Report

The report of the Financial and Membership Department was presented in writing and was filed.

Auditing and Appropriations Committee

The budget for 1984, and the minutes of the December 9, 1983 meeting of the Auditing and Appropriations Committee were presented by Dr. Abromowitz. The budget was presented graphically with visual aids to supplement the written material.

The 1984 budget, totalling $3,354,611 *was approved.* Anticipated funds in 1984 total $3,157,372, resulting in a deficit of $197,239.

The minutes were adopted.

Department of Education; Specialty Society and Meeting Management

Department Report

The report of the Department of Education; Specialty Society and Meeting Management was presented in writing, and was filed.

Committee on Education

Mr. Torrens presented the minutes of the December 1, 1983 meeting of the Committee on Education.

Dr. Spragg, the chairman, reviewed the report and presented the recommendation of the Committee that OSMA adopt as guidelines the Accreditation Council for Continuing Medical Education Essentials & Guidelines for Accreditation of Sponsors of Continuing Medical Education for intra-state accreditation. The recommendation *was approved* and adopted.

The minutes were filed.

Department of Government Relations

Department Report

The report of the Department of Government Relations was presented in writing and was reviewed by Messrs. Gillen and Fry. The report was filed.

Ad Hoc Committee to Study OSMA Role in PRO

The minutes of the November 16, 1983 meeting of the Ad Hoc Committee to Study OSMA Role in Peer Review Organization were presented by Dr. Leech and Mr. Gillen.

The report generated further discussion and the Committee was authorized to conduct an open hearing early in 1984 to determine the OSMA members' views on the organization's involvement in or applying for designation as the Physician Review Organization for Ohio (PRO).

The report was filed.

Department of Development and Member Services

Department Report

Mr. Campbell reviewed the written

report of the Department of Development and Member Services.

He presented a new OSMA publication, "Looking for a Great Investment?", which outlines OSMA membership benefits.

The report was filed.

Resolution on Clinic Manager Membership

The Council voted to recommend to the House of Delegates that OSMA extend affiliate membership to members of the Ohio Medical Group Management Association who are employed by fully-licensed Doctors of Medicine and Doctors of Osteopathic Medicine & Surgery.

The Council voted to recommend that the president of OMGMA or his or her designee be invited as an observer to the House of Delegates.

The Council also authorized the preparation of another resolution creating a separate category of membership for partnerships and professional corporations composed of licensed physicians, all of whom are OSMA members. This proposed bylaws change is necessitated by the successful conclusion of litigation with the Ohio Department of Insurance over the PICO/OSMA group policy.

American Medical Association

Dr. Clarke reviewed the Interim Session of the American Medical Association held in Los Angeles.

He reported that the Ohio resolution calling for separate legal counsel to represent medical staffs of hospitals was approved.

The AMA House also approved an Ohio resolution against "therapeutic" substitution by pharmacists with regard to drugs prescribed by physicians.

Dr. Clarke said that the major items discussed were the standards of the Joint Commission on Accreditation of Hospitals; the usual, customary or reasonable vs. indemnity systems of fee reimbursement; and the insanity defense in criminal cases.

He commended Dr. Ray Gifford, chairman, and the AMA Council on Scientific Affairs for the excellence of the reports of that Committee to the House.

The campaign of Dr. W. "Jack" Lewis, Dayton, for re-election to the AMA Board of Trustees, was discussed.

OMERF/Students & Residents

Mr. Saslaw reported on activities of the Foundation and the Students & Residents program.

The Council voted to encourage the members of OSMA to continue to give strong voluntary support to the Ohio State Medical Association Education and Research Foundation Program.

Department of Health Education

Department Report

The written report of the Department of Health Education was reviewed by Mr. Clinger.

He called attention to the new publication "Health and Safety Considerations for Interscholastic Wrestling," published by the Joint Advisory Committee on Sports Medicine of OSMA and the Ohio High School Athletic Association, in cooperation with the Ohio High School Wrestling Coaches Association.

The report was filed.

Department of Staff Counsel

The written report of the Department of Staff Counsel was reviewed by Mr. Mulgrew.

Federal Legislation

Mr. Mulgrew discussed Federal legislative developments, including the Congress's refusal to enact mandatory assignment over the physicians' objections. He described current legislative issues including "Baby Doe" regulations and funding for the National Institutes of Health.

Ohio State Medical Board

Mrs. Costello reported on recent meetings of the Ohio State Medical Board.

Department of State Legislation

Mr. Burkland presented the report of the Department of State Legislation and reviewed the Department's written summary of pending legislation.

He reported the passage of S.B. 269, the Certificate of Need Moratorium Bill. The bill will be effective upon signature of the Governor on December 12, and continue in effect until July 1, 1984.

The report of the Department was filed.

Malpractice Reform Legislation (Am. Sub. H.B. 682)

Mr. Pohlman reviewed the experience with mandatory non-binding arbitration in medical professional liability cases, indicating that the process is not working and wastes time and money. Efforts to repeal this feature of Am. Sub. H.B. 682 are being considered.

Department of Communications

Ms. Doll reviewed media activities occurring since the last meeting of the Council, and future plans of the department.

The Ohio State Medical Journal and *Synergy* cost projections for 1984 were very favorable, according to Ms. Doll.

Medical Society supplements in local newspapers were discussed by Ms. Mullinax and one published by the Tuscarawas County Medical Society, with the assistance of the Communications Department, was distributed.

Department of Marketing and Field Service

Mr. Holcomb reviewed the written report of the Department of Marketing and Field Service. The report was filed.

Task Force on Marketing and Competition

Mr. Holcomb presented the minutes of the November 17, 1983 meeting of the Task Force on Marketing and Competition.

The Council *approved* an appropriation of $2,000 from the emergency fund for expansion of the physician-placement model information base, by entering information on physicians in Ohio as compiled by the Ohio Board of Regents.

The minutes were filed.

Councilor Reports

The Councilors reported on the activities in their districts.

Task Force on Health Care Costs

Dr. Irons reviewed the activities of the OSMA Task Force on Health Care Costs and discussed the proceedings of the Governor's Commission on Ohio Health Care Costs. He requested the OSMA Task Force on Professional Liability prepare information on tort liability reforms for submission in February to the Governor's Commission.

General Counsel's Report

Mr. Pohlman reported to the Council on recent developments in the following court cases:

1) State of Ohio vs. Joint Commission on Accreditation of Hospitals;
2) Joint Underwriting Authority federal tax refund case; and
3) Advance Plan Suit in Stark County.

The Council was recessed.

The Council then met in Closed Session.

The Council was reconvened and voted to continue as a party plaintiff in the legal action by the Ohio State Medical Board against the Ohio Nurses Association and the Ohio Board of Nursing regarding the unauthorized practice of medicine by nurses. (Dr. Reed dissenting.)

OSMA Auxiliary

The report of the Auxiliary was presented in writing and was reviewed by Mrs. Brown and was filed.

Ohio Director of Health

Dr. David L. Jackson, Ohio Director of Health, addressed the Council.

He discussed the issue of organ transplant services in Ohio and the problems of choices as to recipients of organs. He asked for a nominee from the OSMA to a proposed Task Force to study the matter.

Discussions arising from the fact that 10 hospitals are doing coronary bypass procedures in Cuyahoga County were presented by the Director. He asked for assistance in developing a mechanism to study this matter.

He mentioned S.B. 269, the Certificate of Need Moratorium legislation, recently passed by the Ohio General Assembly.

Practice issues between the nursing and medical professions were discussed by the Director and he proposed a study committee representing OSMA, the Ohio State Medical Board, the Ohio Nurses Association, the Ohio Board of Nursing, a medical educator, a nursing educator, Dr. Jackson, and a chairperson.

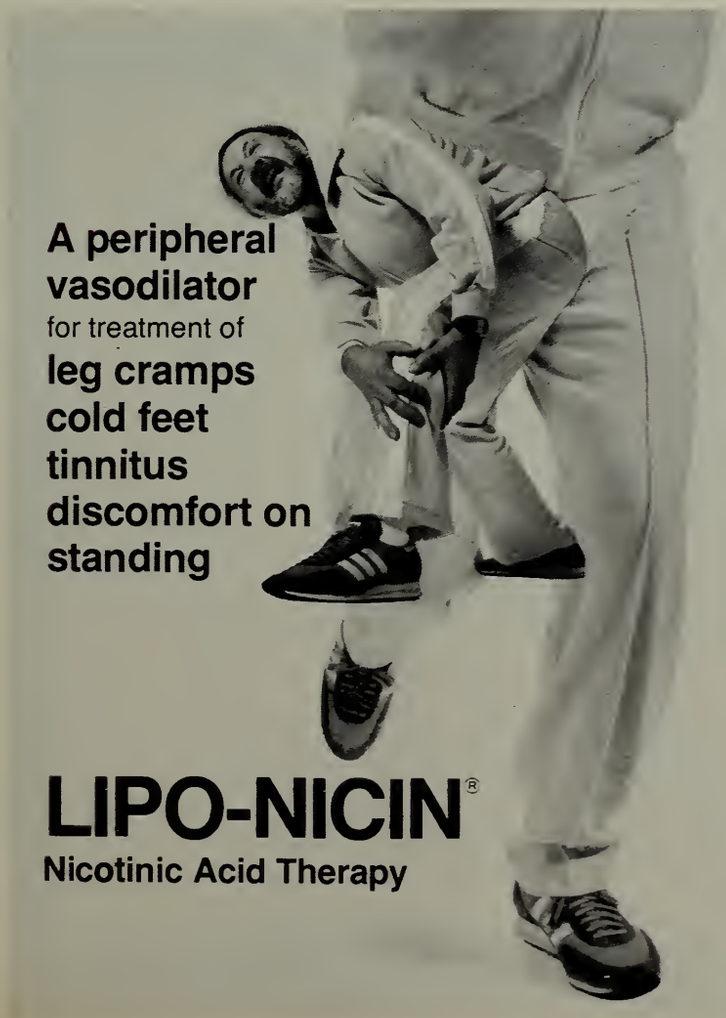
He spoke of the Governor's Task Force on Ohio Health Care Costs and some of the ideas which have been proposed for discussion.

There being no further business, the meeting of the Council was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

Cincinnati plans meeting

CURRENT CONCEPTS IN NUTRITIONAL SUPPORT: May 10-11; Netherland Plaza Hotel, Cincinnati; sponsor: University of Cincinnati Medical Center; 12 credit hours; fee: $250 with text, $200 without text, reduced fees for allied health personnel and residents; contact: Janet Eckart, Program Coordinator, University of Cincinnati College of Medicine, 231 Bethesda Avenue, Cincinnati, OH 45267, phone: 513/872-5851.



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Pyridoxine HCL (B-6) .....10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
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Immediate Release
LIPO-NICIN®/250 mg.
Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide.....75 mg.
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Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

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Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide.....75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

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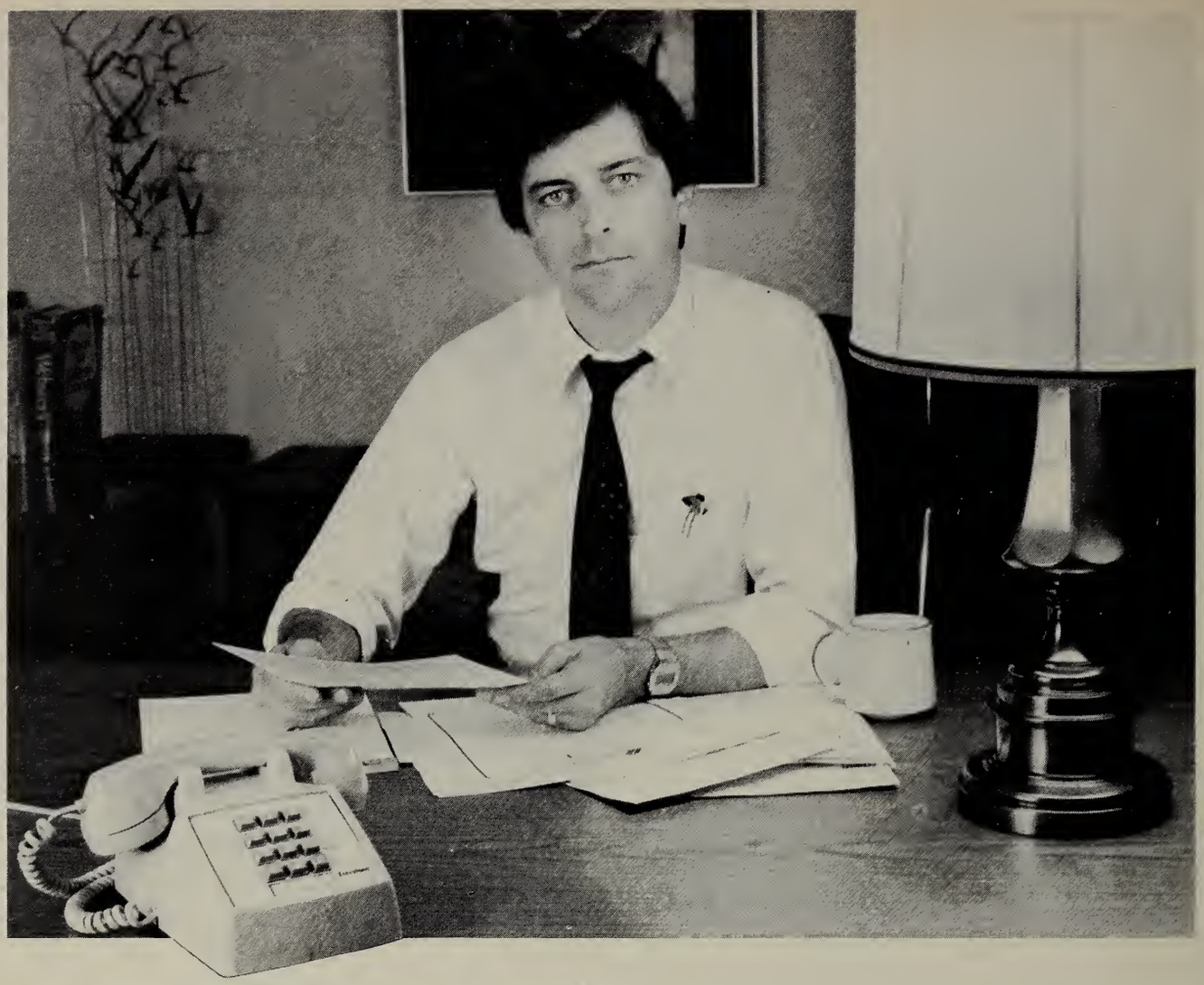
Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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Obituaries

WILLIAM ADKINS, SR., MD, Troy; University of Cincinnati, 1938; age 64; died January 2, 1984; member OSMA and AMA.

MILLARD C. BEYER, MD, Akron; St. Louis University School of Medicine, St. Louis, Missouri, 1930; age 78; died November 28, 1983; member OSMA and AMA.

ROBERT C. CAHILL, MD, Attica; Ohio State University College of Medicine, 1943; age 67; died December 16, 1983; member OSMA and AMA.

BERTWIN EINFALT, MD, Hubbard; University of Illinois College of Medicine, Chicago, Illinois, 1960; age 49; died December 28, 1983; member OSMA and AMA.

STANLEY L. FELDMAN, MD, Cleveland; Ohio State University College of Medicine, 1936; age 72; died December 25, 1983; member OSMA.

CLARENCE FITZPATRICK, MD, Jackson; Ohio State University College of Medicine, 1923; age 85; died December 27, 1983; member OSMA and AMA.

JOHN C. GAEKE, DO, Westlake; College of Osteopathic Medicine and Surgery, Des Moines, Iowa, 1972; age 38; died December 21, 1983; member OSMA and AMA.

JOHN HENRY KERRIGAN, MD, Sidney; Case Western Reserve University School of Medicine, 1943; age 65; died December 22, 1983; member OSMA and AMA.

OTTO L. PLAUT, MD, Canton; Universitat Leipzig Medizinische Fakultat, Saxony, Germany, 1920; age 90; died December 20, 1983; member OSMA and AMA.

ANTHONY D. RETIKAS, MD, Cleveland; Columbia University College of Physicians and Surgeons, New York, New York; died December 10, 1983; member OSMA and AMA.

HARRY E. SHILLING, MD, Brookville, Florida; University of Cincinnati College of Medicine, 1938; age 71; died December 27, 1983; member OSMA and AMA.

JAMES E. SLIVKA, MD, Cleveland; Case Western Reserve University School of Medicine, 1931; age 79; died December 5, 1983; member OSMA and AMA.

LEWIS R. SOLOWAY, MD, Cleveland; University of Cincinnati College of Medicine, 1939; age 71; died December 11, 1983; member OSMA and AMA.

DONALD E. YOCHEM, MD, Columbus; University of Chicago Pritzker School of Medicine, Chicago, Illinois, 1931; age 80; died December 23, 1983; member OSMA and AMA.

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March

ACCIDENTS OR ABUSE: RECOGNIZING THE DIFFERENCE: March 20; Hyatt Regency Hotel, 350 North High Street, Columbus; sponsor: Children's Hospital, Columbus; 5.5 credit hours; fee: $50; contact: Becky Martin, Program Coordinator, Children's Hospital, 700 Children's Drive, Columbus, OH 43205, phone: 614/461-2914.

ISSUES IN THE TREATMENT OF THE DANGEROUS PATIENT: March 26; Quality Inn, Sinclair Road at I-71, Columbus; sponsor: Harding Hospital, Worthington; 6 credit hours; fee: $50; contact: Symposia Registrar, Harding Hospital, 445 E. Granville Road, Worthington, OH 43085, phone: 614/885-5381, ext. 326.

April

2nd ANNUAL INFECTIOUS DISEASE CONFERENCE: April 4; Hyatt Regency Hotel, 350 North High Street, Columbus; sponsor: Children's Hospital, Columbus; 6 credit hours; fee: $50; contact: Becky Martin, Program Coordinator, Children's Hospital, 700 Children's Drive, Columbus, OH 43205, phone: 614/461-2914.

PORTAL HYPERTENSION: April 5; Finnegan Auditorium, St. Elizabeth Hospital, Youngstown; sponsor: St. Elizabeth Hospital; co-sponsor: Northeastern Ohio Universities College of Medicine; 2½ credit hours; No fee; contact: Rashid Abdu, M.D., St. Elizabeth Hospital, 1044 Belmont Avenue, Box 1790, Youngstown, OH 44501, phone: 216/746-7211, ext. 3124.

20TH ANNUAL CLEVELAND RHEUMATISM SOCIETY SYMPOSIUM: April 11; Cleveland Marriott Inn, 4277 West 150th Street; sponsor: Arthritis Foundation; co-sponsor: Cleveland Clinic Educational Foundation; 6 credit hours; fee: $60; contact: Jill Alley, Arthritis Foundation, 11416 Bellflower Avenue, Cleveland, OH 44106, phone: 216/791-1310.

THE YOUNG ATHLETE: ADOLESCENTS IN SPORTS: April 11; The Daytonian Hilton Hotel; sponsor: Wright State University School of Medicine; 6 credit hours; fee: $65; contact: Mary B. Fisher, Dept. of PMCE, Box 927, Dayton, OH 45401, phone: 513/429-3200, ext. 377.

INFECTIOUS DISEASES & ANTIBIOTICS IN CLINICAL PRACTICE UPDATE 1984: April 12; Holiday Inn, Troy; sponsor: Dettmer Hospital; 6 credit hours; fee: $60; contact: Gerard F. Wolf, M.D., D.M.E., 145 Sunset Drive, Piqua, OH 45356, phone: 513/773-8323.

CONTROVERSIES IN THE MANAGEMENT OF LYMPHOMAS: April 12; Westin Hotel, Cincinnati; sponsor: University of Cincinnati College of Medicine; cosponsor: American Cancer Society; 6 credit hours; fee: $50, $25 for residents and other health professionals; contact: Orlando J. Martelo, M.D., 231 Bethesda Avenue, M.L. #562, Cincinnati, OH 45267, phone: 513/872-4233.

CURRENT CONCEPTS IN RHEUMATOLOGY: April 14; TriRivers Vocational School Auditorium; sponsor: Community Med-Center Hospital, Marion; 6 credit hours; fee: $30, $10 for students or physicians-in-training; contact: Craig S. Thompson, M.D., 1040 Delaware Avenue, Marion, OH 43302, phone: 614/387-0850.

PEDIATRIC UROLOGY: AN UPDATE: April 21; Stouffer's Inn On the Square, Cleveland; sponsor: Case Western Reserve University, School of Medicine; 6 credit hours; fee: $50; contact: Division of Urology, Case Western Reserve University School of Medicine, 2065 Adelbert Road, Cleveland, OH 44106, phone: 216/444-3009.

ANNUAL NICHOLAS J. THOMPSON CANCER UPDATE: GYN MALIGNANCIES: April 25; The Daytonian Hilton Hotel, Dayton; sponsor: Wright State University School of Medicine; 7 credit hours; fee: $60, $50 Wright State faculty, $25 nurses; contact: Mary B. Fisher, Dept. of PMCE, Box 927, Dayton, OH 45401, phone: 513/372-7140.

THYROID AND PARATHYROID DISEASE: April 26; Finnegan Auditorium, St. Elizabeth Hospital, Youngstown; sponsor: St. Elizabeth Hospital; co-sponsor: Northeastern Ohio Universities College of Medicine; 2¼ credit hours; no fee; contact: Rashid Abdu, M.D., St. Elizabeth Hospital, 1044 Belmont Avenue, Box 1790, Youngstown, OH 44501, phone: 216/746-7211, ext. 3124.

PEDIATRIC UPDATE ON EMERGENCY MEDICINE: April 27-28; Quaker Square Hilton Inn, Akron; sponsor: Children's Hospital, Akron; 12 credit hours; fee: $150, $25 for physicians-in-training and allied health personnel; contact: Max E. Griffin, M.D., 281 Locust Street, Akron, OH 44308, phone: 216/379-8790.

DIFFERENTIAL DIAGNOSIS IN SURGICAL PATHOLOGY: April 28; Bunts Auditorium, the Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 6 credit hours; fee: $65, $45 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

May

DIAGNOSIS AND TREATMENT OF HEADACHES IN ADULTS AND CHILDREN: May 2; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 6 credit hours; fee: $75; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland OH 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

SPORTS MEDICINE SYMPOSIUM FOR PHYSICIANS: May 3-4; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: $150, $100 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland, OH 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

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Resolutions Affecting OSMA Constitution and Bylaws

SINGLE SHOT VOTING

Whereas, It is important for every OSMA member's ballot to count equally in the outcome of an election and failing to vote for the number of candidates needed to fill the positions available may give unequal weight to a ballot; and

Whereas, Delegates and alternate delegates to the American Medical Association have been chosen by a method of voting referred to by Sturgis (OSMA Parliamentary authority) as "Simultaneous election of candidates to several positions of equal rank"; and

Whereas, Members of the 1982 OSMA House of Delegates were surveyed on acceptable voting procedure changes to streamline voting for Delegates and Alternate Delegates to the AMA House; and

Whereas, Seventy (70) of the one hundred fifteen (115) delegates responding supported the proposal that each ballot to be valid must contain a vote for each position to be filled thus invalidating "single shot" ballots; therefore be it

RESOLVED, That Chapter 5, Section 7 of the Bylaws be amended by adding at the end of the third and last paragraph the following: "No ballot shall be counted if it contains fewer or more votes than the number of positions to be filled or if the ballot purports to cast more than one vote for any nominee." (For example: If upon any ballot the number of positions to be filled is four (4), then each delegate voting must vote for four (4) of the nominees for such positions.)

REVISED VOTING PROCEDURE

Whereas, The election of AMA delegates and alternate delegates to the AMA House at the 1982 OSMA House of Delegates took over six hours; and

Whereas, The Council surveyed the members of the OSMA House of Delegates on possible changes in voting procedures used in electing delegates and alternate delegates to the AMA; and

Whereas, Sixty-one (61) of the one hundred fifteen (115) delegates responding supported changing the procedure to drop the two candidates receiving the lowest number of votes until there are two more nominees than positions to be filled; therefore be it

RESOLVED, That Chapter 5, Section 7 of the Bylaws be amended as follows:

In the event there is only one position to be filled, the nominee receiving the majority of all votes cast shall be declared elected. In case no nominee receives a majority on the first ballot, ~~the nominee~~ NOMINEES receiving the ~~lowest~~ LOWER number of votes shall be dropped ~~and a new ballot taken; this procedure shall be continued until one of the~~ UNTIL THE TWO NOMINEES WITH THE GREATEST NUMBER OF VOTES REMAIN. The nominee receiving a majority of all votes cast whereupon he shall be declared elected.

In the event there is more than one position to be filled from among any number of nominees, a nominee, in order to be declared elected must receive the votes of a majority of those voting. ~~provided, however, that~~ If upon any ballot the number of nominees receiving a majority vote is greater than the number of positions to be filled on such ballot, those nominees (not to exceed the number of positions to be filled on such ballot) receiving the greatest number of votes shall be declared elected. If upon any ballot some but not all of such positions are filled, a new ballot shall be taken. ~~from among all of the remaining nominees; and~~ NOMINEES RECEIVING THE LOWER NUMBER OF VOTES SHALL BE ELIMINATED UNTIL THERE ARE TWO MORE NOMINEES ON THE NEW BALLOT THAN THE NUMBER OF POSITIONS AVAILABLE (FOR THE NEW BALLOT). On such new ballot a nominee, in order to be declared elected, must receive the votes of a majority of those voting, provided, however, that if upon such new ballot the number of nominees receiving a majority vote is greater than the number of positions to be filled on such ballot, those nominees (not to exceed the number of positions to be filled on such ballot) receiving the greatest number of votes cast shall be declared elected. If upon any ballot no nominee receives the votes of a majority of those voting, the nominees receiving the lower number of votes shall be dropped ~~and~~ UNTIL THERE ARE TWO MORE NOMINEES THAN POSITIONS AVAILABLE, THEN a new ballot will be taken. ~~this procedure shall be~~ THIS PROCEDURE SHALL BE continued until all of such positions have been filled.

ESTABLISHMENT OF MEDICAL STAFF SECTION

WHEREAS, At its 1983 Annual Meeting, the American Medical Association House of Delegates adopted Resolution 149 — "Establishment of State Hospital Medical Staff Sections." Resolution 149 said:

RESOLVED, That the American Medical Association House of Delegates encourage every state medical association to establish a statewide hospital medical staff section"; and

WHEREAS, The OSMA House of Delegates at its 1983 Annual Meeting instructed the Council to establish a Committee on a Hospital Medical Staff Section to monitor activities until the 1984 Annual Meeting; therefore be it

RESOLVED, That the House of Delegates instructs the Council to establish an OSMA Hospital Medical Staff Section; and be it further

RESOLVED, That the Hospital Medical Staff Section meet prior to the Annual Meeting of the Association to elect a delegate to the Annual Meeting; and be it further

RESOLVED, That the OSMA Constitution and Bylaws be amended as follows:

CONSTITUTION ARTICLE IV HOUSE OF DELEGATES

(page 2, column 1, second paragraph) . . ., but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the student member of each medical school elect their own delegate; THE HOSPITAL MEDICAL STAFF SECTION SHALL HAVE ONE REPRESENTATIVE TO THE HOUSE OF DELEGATES COMMENCING WITH THE ANNUAL MEETING IN 1985, SAID DELEGATE TO BE SELECTED IN ACCORDANCE WITH BYLAWS OF THE MEDICAL STAFF SECTION TO BE APPROVED BY COUNCIL: (4) delegates and alternate delegates. . . .

BYLAWS CHAPTER 4 THE HOUSE OF DELEGATES

SECTION 4 REPRESENTATIVE OF HOSPITAL MEDICAL STAFF SECTION

THE HOSPITAL MEDICAL STAFF SECTION SHALL HAVE ONE DELEGATE AND ALTERNATE DELEGATE WHO MUST BE ACTIVE MEMBERS OF THE OHIO STATE MEDICAL ASSOCIATION. IN CASE A DELEGATE OR ALTERNATE DELEGATE IS UNABLE TO SERVE, THE CHAIRMAN OF THE SECTION MAY AT ANY TIME CERTIFY TO THE CHAIRMAN OF THE COMMITTEE ON CREDENTIALS THE NAME OF AN ACTIVE MEMBER OF THE ASSOCIATION TO SERVE IN PLACE OF THE ABSENT DELEGATE OR ABSENT ALTERNATE DELEGATE. THE COMMITTEE ON CREDENTIALS SHALL RULE ON THE ELIGIBILITY OF SUCH CERTIFIED INDIVIDUAL OR INDIVIDUALS TO ACT IN THE PLACE AND STEAD OF SUCH ABSENT DELEGATE OR ALTERNATE DELEGATE.

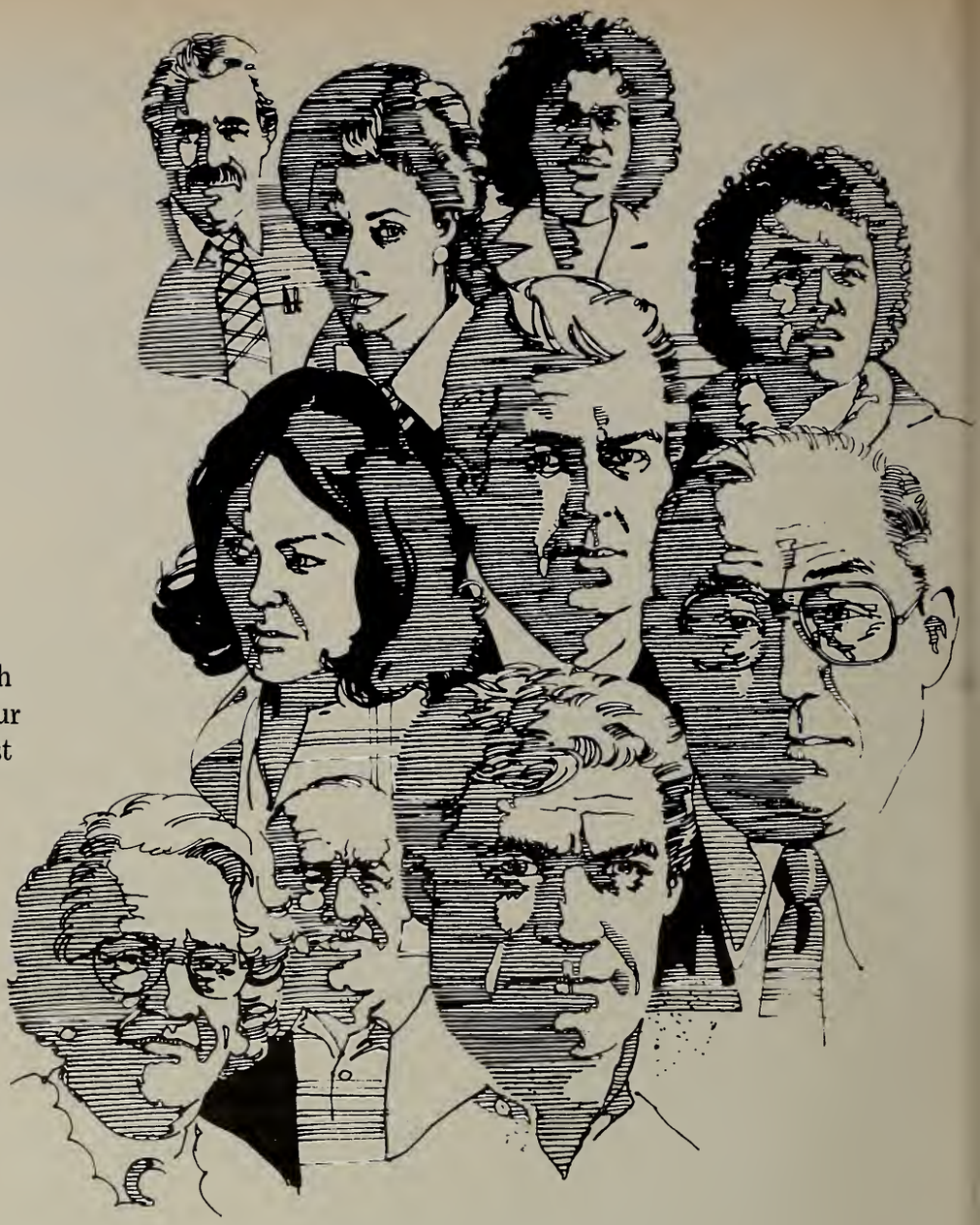
THE HOSPITAL MEDICAL STAFF SECTION DELEGATE SHALL HAVE ALL RIGHTS, PRIVILEGES AND DUTIES AS OTHER DELEGATES. THE DELEGATE WILL BE SEATED IN THE HOUSE OF DELEGATES WITH THE COUNCILOR DISTRICT IN WHICH HIS/HER COUNTY MEDICAL SOCIETY IS REPRESENTED.

Previous Section 4 through 10 to be renumbered.

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OMGMA MEMBERS AS OSMA AFFILIATE MEMBERS

WHEREAS, Active and allied members of Ohio Medical Group Management Association serve as professional medical practice managers for OSMA members; and

WHEREAS, Many business related recommendations and decisions involve the members of OMGMA; and

WHEREAS, A closer, more well-informed and educated relationship between members of OMGMA and OSMA would potentially be of significant benefit to both organizations, their members and the public; therefore be it

RESOLVED, That the OSMA Bylaws, Chapter 1, Section 2(h) be amended as follows to provide for membership in OSMA for active and allied members of OMGMA:

"(h) Affiliate Members. Executives of the Ohio State Medical Association, county medical societies, and other medical organizations and specialty societies in Ohio with three years or more experience in the sponsoring organization are eligible for Affiliate Membership in the Ohio State Medical Association. AN ACTIVE OR ALLIED MEMBER OF THE OHIO MEDICAL GROUP MANAGEMENT ASSOCIATION IS ELIGIBLE FOR AFFILIATE MEMBERSHIP IN THE OHIO STATE MEDICAL ASSOCIATION. AN ACTIVE OR ALLIED MEMBER OF THE OMGMA ELIGIBLE FOR OSMA MEMBERSHIP MUST BE A FULL TIME EMPLOYEE WHO ACTS IN A MANAGERIAL CAPACITY WITH A MEDICAL GROUP PRACTICE COMPOSED OF OHIO LICENSED MEDICAL DOCTORS OR DOCTORS OF OSTEOPATHIC MEDICINE AND SURGERY. Such Affiliate Membership shall be at the pleasure of the Council. An Affiliate member shall pay no dues or assessment.

DUES INCREASE

WHEREAS, inflation outpaced the 15% OSMA dues increase in 1980; and the OSMA has continued to provide services to its members despite budgetary constraints; and,

WHEREAS, the OSMA has exhaustively sought non-dues revenue, which now represents 30% of the association's income, to supplement the dues and keep the members' dues rate at the lowest level; and,

WHEREAS, Ohio is considered among the top state medical associations in the country with vigorous programs to meet members needs, but ranks fortieth in its current dues-rate assessed to its members; and,

WHEREAS, the OSMA will be using its only reserve to fund a budget deficit in 1984, and it must continue to meet the onslaught of challenges brought about by changing attitudes of the public and government concerning the provision of medical care; and,

WHEREAS, representation of the members continues to increase at the legislature, with state and federal rule-setting bodies, the state medical board, the media, the public, the membership and with third party payers; and,

WHEREAS, the OSMA must be ready to respond on behalf of its members to health care issues such as DRG's, alternative health care delivery systems, changes in hospital medical staff and competition; and,

WHEREAS, the OSMA can only maintain its position as the spokesman for the physicians of Ohio under the umbrella which unites all specialties of practice, residents, and students of medicine with adequate financial resources, THEREFORE, BE IT

RESOLVED that the dues of the Ohio State Medical Association be increased by one hundred dollars over a three-year period in the following increments: from $195.00 to $250.00 for dues-year 1985; from $250.00 to $275.00 for dues-year 1986; and from $275.00 to $295.00 for dues-year 1987 and thereafter.





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INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure, intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8833/384

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

OSMA 1984 Annual Meeting
May 18-23, 1984

Preliminary Schedule

FRIDAY, MAY 18, 1984

CC — Convention Center

CH — Clarion Hotel

8:30 AM to 11:30 AM	**Breakfast and Meeting — OSMA Council** Ivory B, CH **Adjournment**
8 AM	**General Registration,** Upper Lobby, CC
9 AM to 12 Noon	**Pediatrics Meeting** Room 25, CC
10 to 11:30 AM	**Hospital Medical Staff Section Meeting** Bronze A, CH
12 Noon to 2 PM	**OMPAC Board Luncheon** Losantiville Room, 2nd Floor, CH
12 Noon	**Emergency Resolutions Committee Luncheon** Ivory A, CH
1 PM	**OSMA Delegation to AMA** Bamboo A & B, CH
	HOUSE OF DELEGATES
3 PM	Registration, Upper Lobby, CC
5:30 to 6:45 PM	Dinner Grand Ballroom B, CH
7 PM	1st Session Rooms 20, 21, 22, 27 & 28, CC
4 to 5:30 PM	**COUNCILOR DISTRICT CAUCUS MEETINGS**

District 1	Cabana A & B, CH
District 2	Bronze B, CH
District 3	Butler Room, CH, 1st Floor
District 4	Room 25, CC
District 5	Commodore Room, CH, 1st Floor
District 6	Room 26, CC
District 7	Suite, CH
District 8	Suite, CH
District 9	Suite, CH
District 10	Ivory A, CH
District 11	Warren Room, CH, 1st Floor
District 12	Suite, CH
MSS	Suite, CH

FOLLOWING HOUSE OF DELEGATES

Reception sponsored by Cincinnati Academy of Medicine and other 1st District Counties
Bronze A & B, CH

SATURDAY, MAY 19, 1984

CC — Convention Center

CH — Clarion Hotel

9 AM to 12 Noon	**Resource Center and Coffee Lounge**
7 to 8 AM	**House of Delegates Breakfast** Grand Ballroom B, CH
8 AM to 1:30 PM	**Reference Committees** Resolutions Committee No. 1, Room 2, CC Resolutions Committee No. 2, Room 3, CC Resolutions Committee No. 3 and President's Address, Room 15, CC Nominating Committee, Room 4, CC
8 AM to 4 PM	**General Registration** Upper Lobby, CC
11:15 AM to 2 PM	**OMPAC Reception,** Grand Ballroom Foyer, CH **OMPAC Luncheon,** Grand Ballroom A & B, CH
2 to 5 PM	**PACO Program** (Computer Demonstration) Room 23, CC
4:30 to 6 PM	**Medical Mutual & OMIM Reception** Bronze A & B, CH
6:15 PM	**Buses at Clarion Hotel for All Member Party**

continued on page 232

ZORprin® (ASPIRIN) ZERO ORDER RELEASE

Arthritis Therapy That Checks Out.

- Gastric distress is reduced. pH-dependent matrix virtually doesn't release in acidic stomach.
- ZORprin® (aspirin) is released in the alkaline environment of the small intestine.
- Zero-order release delivers drug at a constant rate, reducing serum peaks and valleys.



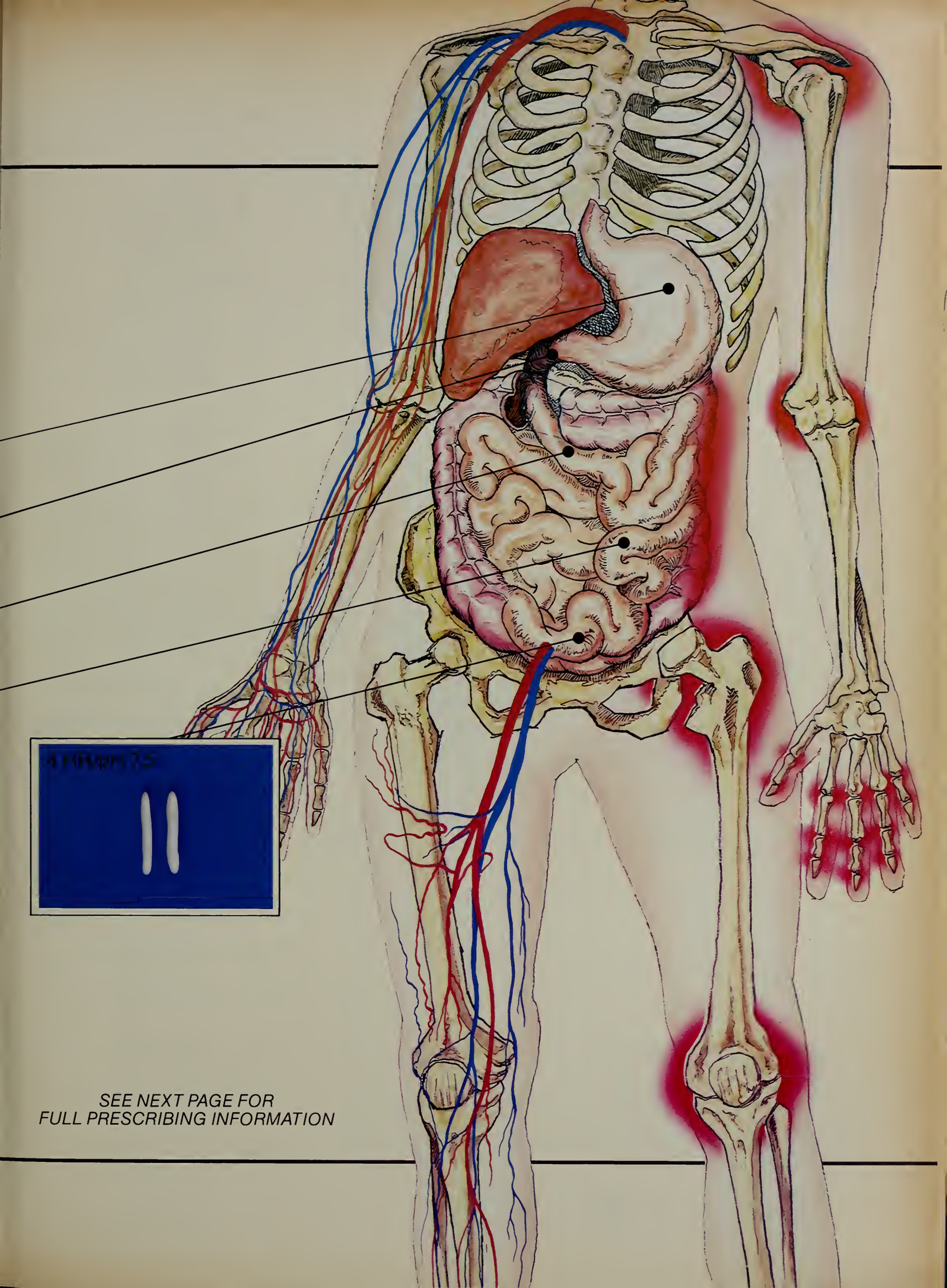


- Convenient b.i.d. dosage...enhances patient compliance.
- Economical...comparable efficacy and safety as other NSAIDs, yet costs approximately one-half as much.
- Your first step in arthritis therapy... **ZORprin®** (ASPIRIN) Zero-Order Release.

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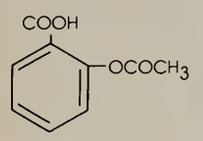


SEE NEXT PAGE FOR
FULL PRESCRIBING INFORMATION

ZORprin® (ASPIRIN) Zero-Order Release

DESCRIPTION: Each capsule-shaped tablet of Zorprin contains 800 mg of aspirin, formulated in a special matrix to control the release of aspirin after ingestion. The controlled availability of aspirin provided by Zorprin approximates zero-order release, the *in vitro* release of aspirin from the tablet matrix is linear and independent of the concentration of the drug. □ **CLINICAL PHARMACOLOGY:** Aspirin, as contained in Zorprin, is a salicylate that has demonstrated anti-inflammatory and analgesic activity. Its mode of action as an anti-inflammatory and analgesic agent may be due to the inhibition of synthesis of prostaglandins, although its exact mode of action is not known. □ Zorprin dissolution is pH-dependent. *In vitro* studies have shown very little aspirin to be released in acidic solutions; whereas, Zorprin releases the majority of its aspirin (90%) in a zero-order mode at a neutral to alkaline pH. It is this pH dependence of Zorprin that reduces direct contact between aspirin and the gastric mucosa, resulting in a reduction of its gastrointestinal side-effect potential. □ Bioavailability data for Zorprin have confirmed that plasma levels of salicylic acid and acetylsalicylic acid can be measured 24 hours after a single oral dose. This substantiates a twice daily dose regimen. Multiple dose bioavailability studies showed similar steady-state salicylate levels for Zorprin as for conventional release aspirin using the same total daily dose. Long-term monitoring of salicylate levels showed no signs of accumulation once steady-state levels were reached (4-6 days). □ Studies of *in vivo* prostaglandin levels (PGE2) have shown Zorprin plasma levels of salicylic acid and acetylsalicylic acid to reduce PGE2 levels 14 hours after a single oral 800 mg dose while an equivalent dose of aspirin produced a reduction of PGE2 levels only through six hours. Zorprin's effect on prostaglandins other than PGE2 has not been determined. □ Salicylates are excreted mainly by the kidney, and from studies in humans it appears that salicylate is excreted in the urine as free salicylic acid (10%); salicyluric acid (75%) salicylic phenolic (10%); acyl glucuronides (5%) and gentisic acid (<1%). □ **INDICATIONS & USAGE:** Zorprin is indicated for the treatment of rheumatoid arthritis and osteoarthritis. The safety and efficacy of Zorprin have not been established in those rheumatoid arthritic patients who are designated by the American Rheumatism Association as Functional Class IV (incapacitated, largely or wholly bedridden, or confined to wheelchair, little or no self-care). □ In patients treated with Zorprin for rheumatoid arthritis and osteoarthritis, the anti-inflammatory action of Zorprin has been shown by reduction in pain, morning stiffness and disease activity as assessed by both the investigators and patients. □ In clinical studies in patients with rheumatoid arthritis and osteoarthritis, Zorprin has been shown to be comparable to conventional release aspirin in controlling the aforementioned signs and symptoms of disease activity and to be associated with a statistically significant reduction in the milder gastrointestinal side effects (see ADVERSE REACTIONS). Zorprin may be well tolerated in some patients who have had gastrointestinal side effects with conventional release aspirin, but these patients when treated with Zorprin should be carefully followed for signs and symptoms of gastrointestinal bleeding and ulceration. □ Since there have been no controlled trials to demonstrate whether or not there is any beneficial effect or harmful interaction with the use of Zorprin in conjunction with other nonsteroidal anti-inflammatory agents (NSAI), the combination cannot be recommended (see **Drug Interactions**). □ **Because of its relatively long onset of action, Zorprin is not recommended for antipyresis or for short-term analgesia.** □ **CONTRAINDICATIONS:** Zorprin should not be used in patients known to be hypersensitive to salicylates or in individuals with the syndrome of nasal polyps, angioedema, bronchospastic reactivity to aspirin, renal or hepatic insufficiency, hypoprothrombinemia or other bleeding disorders. Zorprin is not recommended for children under 12 years of age; it is contraindicated in all children with fever accompanied by dehydration. □ **WARNINGS:** Zorprin should be used with caution when anticoagulants are prescribed concurrently, since aspirin may depress platelet aggregation and increase bleeding time. Large doses of salicylates may have hypoglycemic action and enhance the effect of the oral hypoglycemics, concomitant use therefore is not recommended. However, if such use is necessary, dosage of the hypoglycemic agent must be reduced. The hypoglycemic action of the salicylates may also necessitate adjustment of the insulin requirements of diabetics. □ While salicylates in large doses have a uricosuric effect, smaller amounts may reduce water excretion and increase serum uric acid. □ USE IN PREGNANCY: Aspirin can harm the fetus when administered to pregnant women. Aspirin interferes with maternal and infant hemostasis and may lengthen the duration of pregnancy and parturition. Aspirin has produced teratogenic effects and increases the incidence of stillbirths and neonatal deaths in animals. □ If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus. □ Aspirin should not be taken during the last 3 months of pregnancy. □ **PRECAUTIONS:** Appropriate precautions should be taken in prescribing Zorprin for patients who are known to be sensitive to aspirin or salicylates. Particular care should be used when prescribing this medication for patients with erosive gastritis, peptic ulcer, mild diabetes or gout. As with all salicylate drugs, caution should be exercised in prescribing Zorprin for those patients with bleeding tendencies or those on anticoagulants. □ In order to avoid exacerbation of disease or adrenal insufficiency, patients who have been on prolonged corticosteroid therapy should have their therapy tapered slowly rather than discontinued abruptly when Zorprin is made a part of the treatment program. □ Patients receiving large doses of aspirin and/or prolonged therapy may develop mild salicylate intoxication (salicylism) that may be reversed by dosage reduction. □ Salicylates can produce changes in thyroid function tests. □ Salicylates should be used with caution in patients with severe hepatic damage, preexisting hypoprothrombinemia, Vitamin K deficiency and in those undergoing surgery. □ Since aspirin release from Zorprin is pH dependent, it may change in those conditions where the gastric pH has been increased as a result of antacids, gastric secretion inhibitors or surgical procedures. □ **Drug Interactions:** (See **WARNINGS**) Aspirin may interfere with some anticoagulant and antidiabetic drugs. Drugs which lower serum uric acid by increasing uric acid excretion (uricosurics) may be antagonized by the concomitant use of aspirin, particularly in doses less than 2.0 grams/day. Nonsteroidal anti-inflammatory drugs may be competitively displaced from their albumin binding sites by aspirin. This effect may negate the clinical efficacy of both drugs. Also, the gastrointestinal inflammatory potential of nonsteroidal anti-inflammatory drugs may be potentiated by aspirin. The combination of alcohol and aspirin may increase the risk of gastrointestinal bleeding. □ Aspirin may enhance the activity of methotrexate and increase its toxicity. □ Sodium excretion produced by spironolactone may be decreased in the presence of salicylates. Concomitant administration of other anti-inflammatory drugs may increase the risk of gastrointestinal ulceration. Urinary alkalinizers decrease aspirin's effectiveness by increasing the rate of salicylate renal excretion. Phenobarbital decreases aspirin's effectiveness by enzyme induction. □ **Pregnancy Category D.** See **WARNINGS** Section. □ **Nursing Mothers:** Salicylates have been detected in the breast milk of nursing mothers. Because of the potential for serious adverse reactions from aspirin in nursing infants, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the benefit of the drug to the mother. □ **ADVERSE REACTIONS: Hematologic:** Aspirin interferes with hemostasis. Patients with a history of blood coagulation defects or receiving anticoagulant drugs or with severe anemia should avoid Zorprin. Aspirin used chronically may cause a persistent iron deficiency anemia. □ **Gastrointestial:** Aspirin may potentiate peptic ulcer, and cause stomach distress or heartburn. Aspirin can cause an increase in occult bleeding and in some patients massive gastrointestinal bleeding. However, the greatest release of active drug from Zorprin is designed to occur in the small intestine over a period of time. This has resulted in fewer symptomatic gastrointestinal side effects. □ **Allergic:** Allergic and anaphylactic reactions have been noted when hypersensitive individuals have taken aspirin. Fatal anaphylactic shock, while not common, has been reported. □ **Respiratory:** Aspirin intolerance, manifested by exacerbations of bronchospasm and rhinitis, may occur in patients with a history of nasal polyps, asthma, or rhinitis. The mechanism of this intolerance is unknown but may be the result of aspirin-induced shunting of prostaglandin synthesis to the lipoxygenase pathway and the liberation of leukotrienes, e.g. slow-reacting substance of anaphylaxis. □ **Dermatologic:** Hives, rashes, and angioedema may occur, especially in patients suffering from chronic urticaria. □ **Central Nervous System:** Taken in overdoses, aspirin provides stimulation which may be manifested by tinnitus. Following initial stimulation, depression of the central nervous system may be noted. □ **Renal:** Aspirin rarely may aggravate chronic kidney disease. □ **Hepatic:** High doses of aspirin have been reported to produce reversible hepatic dysfunction. □ **OVERDOSAGE:** Overdosage, if it occurs, would produce the usual symptoms of salicylism: tinnitus, vertigo, headache, confusion, drowsines, sweating, hyperventilation, vomiting or diarrhea. Plasma salicylate levels in adults may range from 50 to 80 mg/dl in the mildly intoxicated patient to 110 to 160* mg/dl in the severely intoxicated patient. An arterial blood pH of 7.1 may indicate serious poisoning. The clearance of salicylates in children is much slower than adults and should receive due consideration when aspirin overdosages occur in infants; salicylate half-lives of 30 hours have been reported in infants 4-8 months old. Treatment for mild intoxication should include emptying the stomach with an emitic, or gastric lavage with 5% sodium bicarbonate. Individuals suffering from severe intoxication should, in addition, have forced diuresis by intravenous infusions of sodium bicarbonate and dextrose or sodium lactate. In extreme cases, hemodialysis or peritoneal dialysis may be required. □ (*A plasma salicylate level of 160 mg/dl in an adult is usually considered lethal.) □ **DOSAGE & ADMINISTRATION:** *In order to achieve a zero-order release, the tablets of Zorprin should be swallowed intact. □ Breaking the tablets or disrupting the structure will alter the release profile of the drug. □ It is recommended that Zorprin be taken with sufficient quantities of fluids (8 oz. or more).* □ **Adult Dosage:** For mild to moderate pain associated with rheumatoid arthritis and osteoarthritis, the recommended initial dose of Zorprin is 1600 mg (2-800 mg tablets) twice a day. Because of Zorprin's prolonged release of aspirin into the bloodstream, Zorprin tablets may be taken as a b.i.d. dose. Further adjustment of the dosage should be determined by the physician, based upon the patient's response and needs. Since it will take 4-6 days to reach steady-state levels of salicylic acid with Zorprin, it is recommended dosages be given for at least one week before further adjustment. In general, patients with rheumatoid arthritis seem to require higher doses of Zorprin than do patients with osteoarthritis. □ **Zorprin is not recommended for children below the age of 12.** □ **HOW SUPPLIED: Zorprin Tablets 800 mg;** plain, white capsule-shaped tablets. □ Bottles of 100 Tablets—NDC 0524-0057-01. □ **Caution:** Federal law prohibits dispensing without prescription. □ U.S. Patent No. 4,308,251. □ **Manufactured and Distributed by: BOOTS PHARMACEUTICALS, INC., Shreveport, Louisiana 71106 U.S.A.** 12/8/83 0057-04

The structural formula of aspirin is:



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Annual Meeting Schedule

continued

6:30 PM.	Becky Thatcher Party Boat
7 to 10 PM	Dinner and Entertainment Buses return to hotel following party

SUNDAY, MAY 20, 1984

CC — Convention Center

CH — Clarion Hotel

8 AM to 5 PM	General Registration Upper Lobby, CC
8 AM to	COUNCILOR DISTRICT CAUCUS MEETINGS (Reports ready)
	District 1 — Cabana A & B, CH
	District 2 — Ivory B, CH
	District 3 — Bamboo B, CH
	District 4 — Losantiville, CH
	District 5 — Commodore, CH
	District 6 — Bamboo A, CH
	District 7 — Suite, CH
	District 8 — Suite, CH
	District 9 — Suite, CH
	District 10 — Ivory A, CH
	District 11 — Warren Room, CH
	District 12 — Suite, CH
	MSS — Suite, CH
11:30 AM to 5 PM	Registration, House of Delegates Upper Lobby, CC
12 Noon to 5 PM	Resource Center
1 PM to 10 PM	Final Session, House of Delegates Rooms 20, 21, 22, 27 & 28, CC
6 PM	Dinner, House of Delegates Grand Ballroom B, CH
7 PM	House resumes (if necessary)

MONDAY, MAY 21, 1984

CC — Convention Center

CH — Clarion Hotel

7:30 AM to 5 PM	General Registration Upper Lobby, CC
8 AM to 12 Noon	Ohio Committee on Trauma, ACS, Meeting Room 15, CC
12 Noon to 1 PM	Ohio Committee on Trauma ACS, Luncheon Ivory B, CH
8:30 AM	OSMA Council Meeting/ Breakfast Ivory B, CH
8:30 AM to 12 Noon	Sports Medicine Meeting
12 Noon to 1 PM	Sports Medicine Luncheon
1 PM to 4 PM	Sports Medicine Meeting (resumes)

8:30 AM to 4 PM	Ophthalmology Scientific Meeting w/table top exhibits Room 2, CC
4 to 6 PM	Ophthalmology Business Meeting Room 2, CC
8:00 AM to 12 Noon	Neurology Section Meeting Room 14, CC
12 Noon	Neurology Luncheon Bamboo A, CH
9 AM to 4 PM	Otolaryngology Meeting Room 20, CC
12 Noon	Otolaryngology Luncheon Bronze B, CH
9 AM to 5 PM	Resource Center/Coffee Lounge Upper Lobby, CC
9 AM to 12 Noon	Ohio Society of Internal Medicine Meeting Room 1, CC
10 AM	PICO Shareholders Meeting Room 13, CC
12 Noon to 1:30 PM	Rheumatology Luncheon/ Business Meeting Losantiville, CH
1:30 PM to 5 PM	Rheumatology Meeting Room 4, CC
1 PM to 4 PM	Radiology Meeting Room 21, CC
1 PM to 5 PM	Family Medicine Meeting Room 3, CC
4:30 to 7 PM	Pathologists Board of Governors Meeting Room 5, CC
4:30 to 6:30 PM	Neurosurgery Business Meeting Room 8, CC
7 PM	Cocktails/Dinner (Neurosurgery) Queen City Club

TUESDAY, MAY 22, 1984

CC — Convention Center

CH — Clarion Hotel

7:30 AM to 5 PM	General Registration Upper Lobby, CC
7:30 to 8:30 AM	Neurosurgery Breakfast Ivory B, CH
8:30 AM to 12:10 PM	Neurosurgery Meeting Room 20, CC
12:30 PM to 1:30 PM	Neurosurgery Luncheon Ivory B, CH
1:30 PM	Resume Meeting, Room 20, CC
8 AM to 12 Noon	Ohio Committee on Trauma, ACS, Meeting Room 15, CC
12 Noon	Ohio Committee on Trauma Luncheon Commodore Room, CH
8:30 AM to 12 Noon	Ophthalmology Scientific Meeting Room 2, CC
9 AM to 12:30 PM	Pathology Meeting Room 21, CC
12:30 PM to 1:30 PM	Pathology Luncheon Bronze B, CH
1:30 PM to 5 PM	Pathology Meeting Room 21, CC
9 AM to 5 PM	Resource Center/Coffee Lounge
1 to 5 PM	Dermatology Program Room 1, CC
5 to 11 PM	Ohio Psychiatric Association Council Meeting Room 14, CC
6 to 7 PM	Ohio Psychiatric Association Dinner (Council) Bamboo A, CH

WEDNESDAY, MAY 23, 1984

CC — Convention Center

CH — Clarion Hotel

7:30 AM	General Registration Upper Lobby, CC
8:30 AM to 12:30 PM	Ohio Psychiatric Association Scientific Program Room 3, CC
12:30 PM to 3 PM	Ohio Psychiatric Association Luncheon Bronze B, CH Lunch followed by Business Meeting
8 AM to 12 Noon	Allergy and Immunology Meeting Room 20, CC (luncheon outside hotel)
9 AM to 5 PM	Resource Center/Coffee Lounge
9 AM to 12:30 PM	Plastic Surgery Meeting Room 13, CC
12 Noon to 1:30 PM	Physical Medicine & Rehabilitation Luncheon Bronze A, CH
1:30 to 4 PM	Physical Medicine & Rehabilitation Meeting Room 1, CC
5 PM	Physical Medicine & Rehabilitation Cocktails (cash bar)
5:30 to 6 PM	Physical Medicine & Rehabilitation Dinner Bronze A, CH
12 Noon	Colon & Rectal Surgery Luncheon Bamboo B, CH
1:30 PM	Colon & Rectal Surgery Meeting Room 4, CC
12 Noon to 1 PM	Urological Society Luncheon Ivory B, CH
1 to 3 PM	Urological Society Meeting Room 5, CC
1 to 4 PM	Interprofessional Meeting Room 21, CC

=New Members=

ASHTABULA
Halkur Mohan Kumar, Geneva

CUYAHOGA (Cleveland unless noted)
Nabil Azar
William S. Beshai, Solon
Robert M. Buchsbaum
Richard E. Butin
Anthony A. Caldamone
Jason Chao
Richard S. Glosser
Kiturah Humphrey
I. Alex Iwaniw
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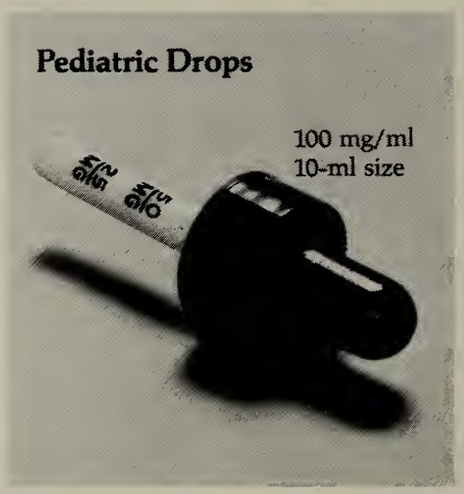
Addendum

The credit line at the end of the article "Where Have All The Patients Gone," by Robert J. McDevitt, MD and Ruth Archer McDevitt, RN, BSN in the February issue should have included that Dr. McDevitt is the Director of the Department of Psychiatry at Good Samaritan Hospital in Cincinnati, Ohio.

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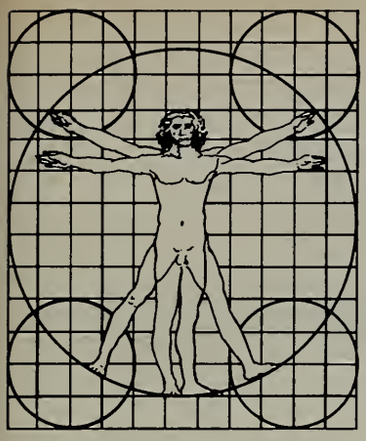


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CLINICAL & SCIENTIFIC

VISUAL LOSS IN GERIATRIC RESIDENTS OF NORTHWESTERN OHIO NURSING HOMES

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Introduction

Visual loss in a geriatric nursing home population has been studied and reported only once, in 1957, by Kornzweig et.al.[1] More recently (1980), the Framingham Eye Study (FES), studied the causes of visual loss in an ambulatory geriatric population.[2] Using the diagnostic criteria of the FES, we studied the causes and prevalence of visual disability in geriatric patients residing in northwestern Ohio nursing homes to determine if visual loss was more common in this confined geriatric population.

Methods

Of the 159 nursing homes in northwestern Ohio, 16 (10%) were selected in 16 different communities (population range 2,000 to 400,000). The nursing homes chosen were thought to represent a cross-section of area facilities. The nursing home administrator solicited participation of the residents. To participate in the study, consent of each resident's legal guardian and personal physician was obtained, in addition to informed consent from each individual resident volunteer. A team of trained interviewers aided each volunteer in the completion of a psychological profile questionnaire. Past medical history was obtained by reviewing each volunteer's nursing home medical records. Lions' Club members performed visual acuity testing and air puff tonometry on each volunteer, using a standard protocol. An ophthalmic technician performed a lensometer check of the current spectacles. An overrefraction was performed, with the best corrected visual acuity recorded. A penlight and Zeiss slit lamp (if possible) examination of the anterior segment and direct and indirect ophthalmoscopy were done by ophthalmologists. In patients who could not cooperate for air-puff tonometry, the ophthalmologists checked the intraocular pressure by Schiotz tonometry (average of three readings) after instillation of proparacaine 0.5% (Ophthaine™). Each eye was dilated with phenylephrine 2½% (Neosynephrine™) and 1% tropicamide (Mydriacyl™), if judged to have a nonoccludable anterior chamber angle. The pupils were dilated 5mm or more prior to direct and indirect ophthalmoscopy. Upon completion of the examination, one drop of 2% pilocarpine was placed in the inferior cul de sac of each eye.

A cataract was diagnosed if the best corrected visual acuity was 20/30 or worse and judged by the examiners to be due to any type of lens opacity.[3] Glaucoma or glaucoma suspect was recorded as the diagnosis if the volunteer had a positive documented history of glaucoma with or without treatment, or if the intraocular pressure by Schiotz tonometer was greater than or equal to 22 mg Hg with a 5.5 gram weight, or if the cup-disc ratio (CDR) was 0.5 or greater either horizontally or vertically in either eye or if a difference in the CDR of 0.2 or greater was found between the two eyes.[4]

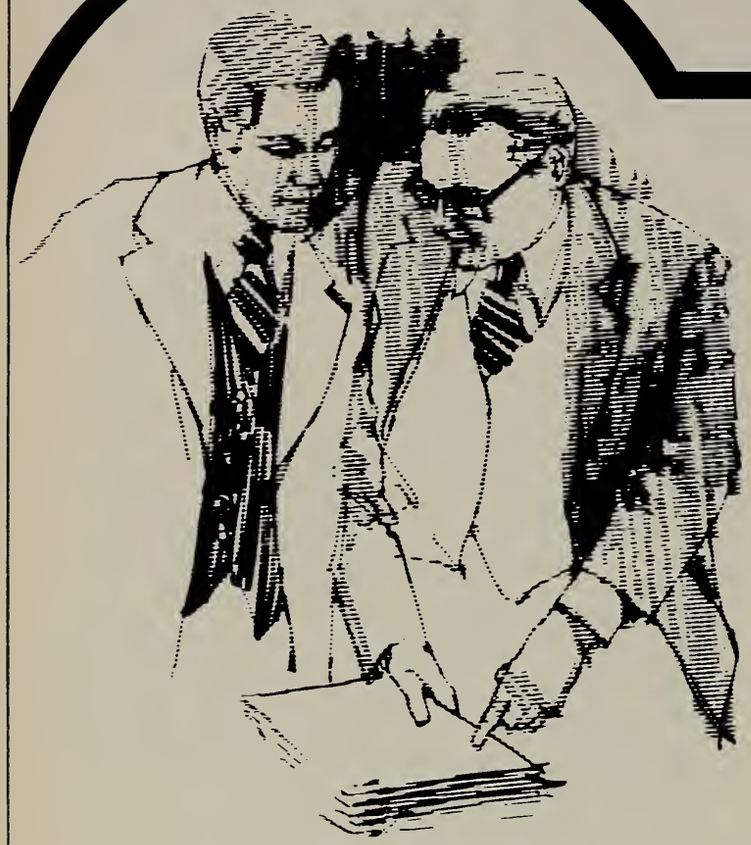
A diagnosis of diabetic retinopathy was made if a volunteer had documented diabetes mellitus (whether or not on therapy) and had ophthalmoscopic evidence of either background diabetic retinopathy (retinal vasculature congestion, capillary microaneurysms, hard exudates, retinal microcystic edema, superficial or deep retinal hemorrhages); preproliferative diabetic retinopathy (soft exudates, retinal venous engorgement and tortuosity); or proliferative diabetic retinopathy (neovascular fronds with or without vitreous hemorrhage.[5] Macular degeneration was diagnosed if the best corrected visual acuity in an eye was 20/30 or worse in the face of macular drusen, pigmentary disturbances, exudate, hemorrhage or scar not due to other retinal pathology such as diabetic retinopathy, myopic degeneration or presumed ocular histoplasmosis syndrome.[6] These criteria for diagnosis were similar to those used in the FES.

A follow-up letter was sent to family physicians and private ophthalmologists responsible for the care of each patient. Also, a letter giving a summary of the data found in each nursing home was sent to the appropriate medical directors and nursing home administrators.

Results

A total of 1,254 patients resided in these 16 nursing homes. Examinations were performed on 408 volunteers (32.5% participation). Of those participating, 132 (32.4%) were men and 276 (67.6%) were women. Overall, the participants in our study

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were much older (77.6% were 75 years old or older) than those in the FES (85% were younger than 75 years of age). All patients were caucasian except for three black men (99.3% vs 99.8% caucasians in the FES).[7]

Of the total patient population 72.3% had cataracts diagnosed in one or both eyes. As expected, the percentage of patients having cataracts increased with age (33.3% of those aged 52 to 64, 68.6% of those aged 65 to 74, 72.7% of those aged 75 to 85 and 79.0% of those aged 86 years or older).In each age group, a greater percentage of women when compared to men had cataracts. Cataracts were found in 278 right eyes (68.1%) and 272 left eyes (66.7%) of the total population.

Macular degeneration ("senile type") was found in 24.5% of those studied. The lowest percentage of patients with macular degeneration (10%) was found in the age group 65 to 74 years. In the 52 to 64 year age group, 14.3% of patients were diagnosed as having macular degeneration in one or both eyes. Similar percentages were found in two older groups; 27.3% in those aged 75 to 85 and 29.6% in those 86 years or older. Macular degeneration was found in 94 right eyes (23.0%) and 81 left eyes (19.8%) of the total population.

Glaucoma or glaucoma suspect was diagnosed in 6.4% of the northwestern Ohio nursing home residents who participated in this study. Glaucoma or glaucoma suspect was diagnosed in 21 right eyes (5.1%) and 18 left eyes (4.1%) in the total population studied.

Diabetic retinopathy was found in 2.4% of this population. Diabetic retinopathy was diagnosed in nine right eyes (2.2%) and four left eyes (1.0%).

A complete medical history was available from a personal physician on each of 346 patients.

In the questionnaire administered to our participants, the most frequent reason for entering a nursing home was "unable to care for myself," usually indicating physical disability, as will be discussed in a separate study. The FES participants were much more mobile than our nursing home residents, half of whom were wheelchair bound.

Corrected visual acuity in the participant's better eye was 20/20-20/40 in 43%, 20/50-20/70 in 26%, 20/60-20/100 in 17% and 20/200 or less (legally blind) in 14% of the participants. Of the total eyes examined, 27% were blind.

Discussion

While the diagnostic criteria in the study of Kornzweig et.al. were not as precisely defined as in our study or in the FES (on which our study is modeled), the prevalence of the four major ocular disorders of aging (cataract, macular degeneration, glaucoma, and diabetic retinopathy) found by Kornzweig, et.al. are very similar to the prevalences we found in our nursing home population.[1] Since Kornzweig, et.al. did not break their population into as many age groups as the FES, most of our discussion will compare our results to those of the FES. Like our study, Kornzweig et.al. examined an older population, one-half of whom were non-ambulatory, as was the case in our study.

In the FES, cataracts were associated with elevated blood sugar, systemic hypertension, and elevated serum phospholipids. They were inversely associated with educational attainment, height, vital capacity and hand strength.[9] The MCO study had a larger percentage of its population in the older age groups (75 years or older); 77.7% compared with approximately 11% (729/5136) in the FES. Even in the younger age groups, cataracts were much more common in our nursing home participants than in the population examined in the FES. Chi square analysis ($P<0.01$) indicates a significantly greater prevalence of cataracts in our nursing home population than in the FES, but only a slightly higher prevalence (72.3%) than found by Kornzweig, et.al.(61%).

Macular degeneration was positively associated with systemic hypertension, left ventricular hypertrophy, and a history of lung infection; it was inversely associated with height, vital capacity, and hand strength in the FES.[8] The total percentage of patients affected by macular degeneration was higher in the MCO study (29.5%). Again, Chi square analysis ($P<0.01$) indicates a significant difference from the total FES population and in the two younger age groups (52-64 and 65-74 years). The prevalence of macular degeneration was similar in the 75-85 year groups in our study and the FES. The overall prevalence was almost identical to that found by Kornzweig, et.al.

Glaucoma has not been associated with single variables previously measured in the FES. However, ocular hypertension has been positively associated with systemic hypertension, elevated blood sugar and increased pulse rate. The incidence of glaucoma was inversely proportional to height.[8] The FES population had glaucoma diagnosed by Goldman Visual field examination, whereas we were not able to perform perimetry in the nursing home setting. The lack of glaucoma patients or suspects in the 52 to 64 year group in our study may be due to the small number of patients in that group. Chi square analysis ($P>0.10$) does not indicate a significant difference between our patients or those studied by the FES or Kornzweig, et.al.

Diabetic retinopathy is positively associated with diabetes, and causally associated with blood sugar and urine sugar.[8] The prevalence of diabetic retinopathy is similar in all three studies ($P>0.05$).

How well do nursing home patients see, regardless of ocular pathology? In the right eye, 6.4% saw 20/20 or 20/25, 41.7% saw 20/30 to 20/50, 25.2% saw 20/60 to 20/100 and 26.7% of the eyes were legally blind (defined as 20/200 or less vision). In left eyes, the percentages were very similar; 20/20-20/25 in 6.9%, 20/30-20/50 in 39.9%, 20/60-20/100 in 26.2%, and 27.0% were legally blind. In the nursing home study of Kornzweig, et.al., 13.9% of eyes were blind. In the FES, only 3.1% of right eyes and 2.7% of left eyes were legally blind.[9]

Only 13% of the total population we studied had a diagnosis of organic brain syndrome or senility. Arthritis, congestive heart failure, and hypertension were the most common diagnoses made by the participants' personal physicians. Stroke, genitourinary disorders, diabetes mellitus, leg and foot problems, and unspecified atherosclerosis each afflicted from 22% to 16% of the patients whose medical records were available to us. By comparison, we found that 14% of these patients were legally blind (best corrected vision of 20/200 or worse in the better eye). For many of these geriatric patients, visual impairment may have been a contributing factor in their decision to enter a nursing home.

Conclusion

A total of 408 residents of Northwest Ohio nursing homes were evaluated and compared to the FES population and the nursing home population studied by Kornzweig, et.al. A significantly greater percentage of our nursing home patients had cataracts or macular degeneration or both than in the non-institutionalized geriatric population studied in the FES. The prevalence of these disorders was almost equal to that found by Kornzweig, et.al. nearly 30 years ago. Over one quarter of our geriatric nursing home patients were legally blind in one eye. Legal blindness (best corrected vision of 20/200 or worse in the better eye) was found in 14%, and this disability may have contributed to the decision to enter a nursing home. **OSMA**

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Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted): Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215. Phone: 614/228-6971.

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1984 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

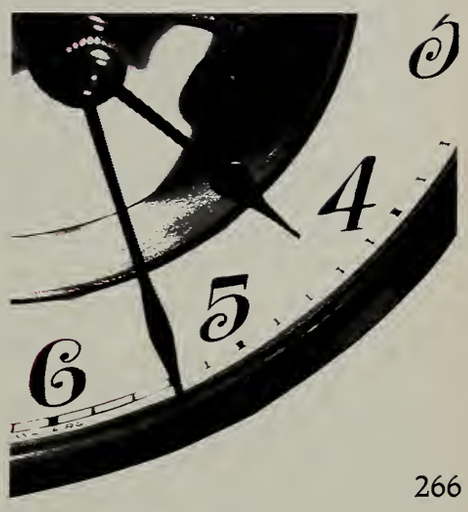
Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

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THE Ohio STATE Medical Journal
(ISSN 0030-1124)

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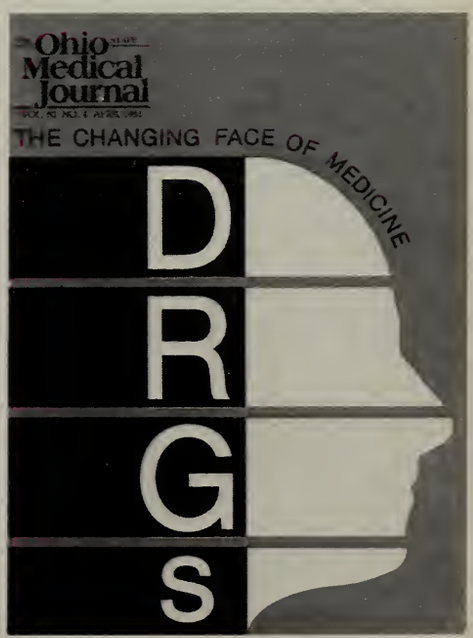
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S. Baird Pfahl, Jr., MD

=PRESIDENTIAL PERSPECTIVES=

Three Reasons to Come to the Annual Meeting

By S. Baird Pfahl, Jr., MD

I extend an invitation to all Ohio physicians to attend the OSMA's Annual Meeting in Cincinnati from Friday, May 18, to Wednesday, May 23. The detailed schedule is listed elsewhere in this issue. I urge you to review it.

Our meeting has three distinct purposes. The first is organizational. It involves the meeting of your representatives to the OSMA's House of Delegates. Many important issues will be raised at this year's Annual Meeting. It is important that your voice be heard on these issues. Your input to your delegate, both personally and on the floor of the Resolution Committees, will help us to arrive at the correct decisions.

Many important issues will be raised at this year's Annual Meeting. It is important that your voice be heard on these issues.

The issues facing medicine today, some of which I have addressed in previous columns, will shape our practices for the future. The Annual Meeting gives you, our OSMA membership, a chance to speak up and more importantly, to be listened to! PLEASE SPEAK UP.

The second purpose of our meeting is medical education. A wide variety of subjects are available to you at a most reasonable COST — FREE — with paid OSMA membership, of course. Mandatory CME can seem like a drag, but the gracious hospitality of the Cincinnati Academy of Medicine and the city itself will make the delivery of medical knowledge almost fun. PLEASE COME AND LEARN.

The third purpose is to hold the annual shareholders meeting of the Physicians Insurance Company of Ohio — your insurance company and its subsidiary companies. This meeting is on Monday, May 21, at 10:00 A.M. COME SEE YOUR INSURANCE COMPANY AT WORK.

As you have surmised by now, we do welcome you at our and your Annual Meeting. See you in Cincinnati. **OSMA**

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The Changing Face of Medicine

Creating a theme for each year's Annual Meeting is no easy project — but this year, our program committee may have arrived at one of the timeliest topics in years.

Certainly, the face of medicine is changing, and changing rapidly.

The program committee elected to focus the Annual Meeting theme specifically on the subject of Diagnostic Related Groups (DRGs), the federally-mandated prospective payment system imposed on hospitals last October for their Medicare patients.

To follow through with this theme, we decided to do an update on DRGs. They have been in existence for several months, now, and we wanted to know how they are working, where the problems lie, and how they are changing the face of medicine. We think you'll agree that the final report makes interesting reading.

DRGs are not the only factors responsible for medicine's changing face, however. Environmental influences can be just as strong, and just as influential. Just ask the American Medical Association (AMA).

The AMA's Committee on Long-range Planning recently published a lengthy and detailed report on the Environment of Medicine. We've synopsized some of it here for you, and we'll follow-up with other articles, based on that report, in subsequent issues. It's information you should know, in order to be better prepared for the future.

Of course, governments have, for years, been one of the biggest factors in the changing face of medicine, and Ohio's state government is really no exception. That's why, when the Governor assembled a Commission to study containing health care costs in our state, the Ohio State Medical Association was right there with a representative — D. Ross Irons, MD, of Bellevue. The story in this issue was based on an interview with Dr. Irons, and outlines both his work on the Commission, and what direction it appears the Commission is heading. After all, whatever actions the state may take as a result of the commission's findings are bound to have an impact on Ohio physicians.

Also in state news . . . last February, in our special "Mental Health" issue, we mentioned that Ohio had recently received a federal grant to study the connection between the homeless and the mental health system. This month, we bring you some news about that study — how it was funded and its purpose. The findings — not yet determined — will have to be reported in a subsequent issue.

And that brings us, full circle, to where we started. For this issue is the Annual Meeting issue — featuring all the programs and information you'll need to plan your trip down to the Queen City this May. The face of medicine is changing — and the best way to keep it moving in the direction *you* want it to is to become involved. The OSMA Annual Meeting may be the best place to start your involvement. Why not make plans to attend this year? — *Karen S. Edwards*

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Letters to the editor

No Back Wards at COPH

To the Editor:

I read with interest your article on Deinstitutionalization in the February, 1984 issue of *The Ohio State Medical Journal.*

The questions you raise are vital ones which need attention by all involved in the mental health system. I am curious, however, as to the need to give such emphasis to the following quote by Ms. Malone:

> "Our cells are beginning to look like the back wards at the Central Ohio Psychiatric Hospital. Everything is the same, they've just changed the address is all. It's the same locked environment, the same oppressive conditions . . ."

I feel it is an inaccurate portrayal of Central Ohio Psychiatric Hospital, and the attempt at comparison was irrelevant to the issue under discussion. While we may have some antiquated facilities, I believe you would find our programming current.

The staff of Central Ohio Psychiatric Hospital is working hard to steadily improve services, facilities, and our image in the community. Your emphasis on an out-dated image undercuts much of that effort.

Sincerely,
C. Dan Miller, Superintendent
Central Ohio Psychiatric Hospital
Columbus, Ohio

They Don't Melt Away . . .

To the Editor:

Thank you for the timely discussion of mental health in the February *Journal.*

I have practiced in Wayne County since 1922, and well remember the sage advice of an older colleague — a native of the area — who said, "don't expect more from a patient than he/she can give."

When deinstitutionalization began, Wayne County had some knowledge of the problems involved, although group homes were formed with competent, 24-hour caretakers present, and the well established Amster Sheltered Work Shop gave help to those able to do simple tasks.

But, these unfortunate people don't melt away. They commit crimes and fill our reformatories. The homeless wander the streets and fill the hunger lines. Indeed, we have an economic, social and medical problem that must be met with skill and ability for all concerned.

Sincerely,
Eva G. Cutright, MD
Wooster

The Stampede to Cut Costs

To the Editor:

The stampede to HMOs, PPOs and IPAs, etc., seems to have lost sight of the purported purpose of the changes in the health care delivery system; namely, a reduction of cost. It is an accepted fact that the cost of primary office based medical care has not risen out of proportion to the rate of inflation. The skyrocketing increase in health care cost is the result of secondary and tertiary care; namely, hospitalization. Office based fee for service primary medical care, with the patient being directly responsible for the bill, is the most cost effective mode of care since it incorporates the inherent fee restraint of the patient looking out for his or her own pocketbook. All of the proposed plans utilize third party payment for primary care which automatically increases (probably doubles) the cost in order to cover the processing in addition to substituting a paid arbitrator to control cost and utilization in place of the free enterprise system of direct consumer control. The logical conclusion is that any reimbursement plan that aspires to be the most economical should utilize fee for service primary care with direct patient responsibility up to a reasonable amount such as $1,000. Secondary and tertiary care could be covered with a possible co-pay or deductible and with reasonable utilization restraints.

Freedom of choice and the free enterprise system has produced the finest country with the best medical care available and I would hate to see us abandon our principles at this point.

As physicians we are not accustomed to thinking in business terms, but in the market place, the company that provides the best quality product or service at the most reasonable price will be the survivor. We in medicine must realize that the same principles apply to us.

Sincerely,
John L. Thinnes, MD
9030 Montgomery Rd.
Cincinnati, Ohio 45242

Addendum

The introduction to the March issue of the *Ohio State Medical Journal* titled, "The Pits and the Pendulum" by Leslie E. Whitmire, MD, was coauthored by L.J. Archambeau, MD, who practices psychiatry with Dr. Whitmire in Toledo.

CORRECTION

In February, Andrey Devenyi-Blitzer was incorrectly identified in our New Member list (from Cuyahoga County) as Audrey Devenyi-Blit.

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Is Ten Percent Enough?

By Ray W. Gifford, Jr., MD

(Reprinted from the Cleveland Physician)

As I look back over the many events that have occurred in the year since we last met here, I am most proud of Project '83. This program has demonstrated in a very real way the human concern and compassion which has traditionally characterized the medical profession.

In this day and age it isn't often that the medical profession is treated kindly by the media. We are often unfairly portrayed as being selfish, insensitive and greedy — accusations which Project '83 and similar programs throughout the nation have eloquently refuted.

Much of the past year has been devoted to problems related to the rising cost of health care. The Academy of Medicine is participating with industry, the Greater Cleveland Hospital Association and representatives of third party carriers in the Utilization Review Coordinating Council (URCC) to monitor hospital utilization. We are also involved with industry, labor, hospital associations, and growth associations in the Greater Cleveland Voluntary Health Planning Association to review and make appropriate recommendations regarding expansion and/or building of new acute care facilities in this area.

Another result of the universal desire to contain health care costs is the competitive movement in the delivery of health care services that threatens our traditional modes of practice. I refer to the IPA, the HMO and the PPO. Solo practitioners are scurrying to take refuge in such systems to protect their practices, and multi-specialty groups are seeking to establish linkages with other hospitals and group practices to insure a referral pattern.

The medical profession is blamed by the government, by industry, and by the press for rising costs of medical care — even though much of it is beyond our control. Physicians' services account for only 19% of the national health care pie. Physicians' fees have increased slightly more than the consumer price index (CPI) over the last 10 years, but due to increasing overhead, net income for physicians has not kept pace with inflation.

The medical profession is blamed for rising costs of medical care — even though much of it is beyond our control.

But there are others who must share the blame for the uncontrolled cost of medical care. To the extent that the escalation of health care costs is due to inefficient management and business practices of hospitals, they are to blame. To the extent that escalation of health care costs is due to the litigious climate and patients' demands for extraordinary and questionably necessary services, the public is to blame. To the extent that escalation of health care costs is due to enormous and outlandish judgments in professional liability suits, the courts are to blame. To the extent that escalation of health care costs is due to legislation that has fostered a surplus of physicians and hospitals, has mandated minimum benefits in insurance contracts and has established a bureaucracy in each hospital to comply with regulations, the government is to blame. To the extent that labor continues to insist on first dollar coverage, they are to blame. To the extent that reimbursement formulas by third party carriers have provided incentives for use of high cost technology over cognitive services, and for hospitalization over outpatient care, they are to blame.

Nevertheless, it is we, as physicians, who are the "gatekeepers" to the hospital which accounts for 41% of the health care pie, and to the myriad diagnostic and therapeutic procedures which have contributed to the escalation of health care costs. It is we who decide when a patient should be hospitalized and for how long; it is we who decide if a patient should have an operation or be admitted to the intensive care unit; it is we who decide if a patient should have a CT scan, endoscopy, coronary angiography or dialysis. It is we who prescribe drugs.

Therefore, we must accept our share of the blame for rising health care costs which in 1982 exceeded 10% of the gross national product for the first time. For reasons that aren't readily

apparent, some economists believe that this is too much. However, relatively, it is no greater than health care expenditures in West Germany or Sweden and only slightly more than in the Netherlands and France. Are jobs provided by the health care industry any less desirable than those provided by the automobile or steel industries? Why is it a sign of economic decadence if a country chooses to spend more on health care and less on something else?

To the extent that the escalation of health care costs is due to inappropriate use of hospitals, procedures, physicians' services and drugs, we are to blame.

But there is a limit to cost savings that can be achieved by more appropriate utilization of hospitals and the tightening of hospital fiscal policies. When the "fat" has been squeezed out, further savings will necessarily encroach upon quality of care for the American people.

Cost containment efforts by the government, by the industry and by third party carriers are always implemented with a passing reference to maintenance of quality of care. More and more this is just lip service as cost containment becomes the overriding concern of federal health planners, health economists, and industry and third party carriers.

Only physicians can judge quality of care. That is why it is so crucial that physicians participate and have input at all levels in the efforts to contain costs, from the halls of congress to the local utilization review committees.

The annual cost of medical care to the American people has increased enormously from $26.9 billion in 1960 to $287 billion in 1981. This represents an increase from 5.3% to 9.8% of the gross national product. What have they received for this considerable expenditure?

I would answer this with the self-serving but true statement: "The best medical care in the world." But how to measure this? Infant mortality has decreased in this country from 26 to 11.7 per 1000 live births in the last 20 years. Average life span has increased from 69.7 years in 1960 to 74.1 years in 1981 (69.9 years for men and 77.6 years for women). Death rate from stroke has declined more than 40% and death rate from heart attack has declined by 30% in the last 10 years. Overall death rate has declined by 25% in the last 20 years. It is estimated that in 1978 alone there were 350,000 fewer deaths than would have been anticipated had the trend in cardiovascular mortality rate of the 1960s continued into the 1970s.

Prolongation of life would seem to be a desirable and a worthwhile accomplishment. But it increases the cost of medical care! For each year we add to the life of a 65-year-old person, we add $2,200 to total health care expenditures. There are now more than 25 million Americans 65 years of age or older and with each of them living longer, the cost of medical care increases. I hesitate to mention this, lest it might suggest to some bureaucrat in HCFA a macabre solution to the problem of Medicare expenditures.

Only physicians can judge quality of care. That is why it is so crucial that physicians participate at all levels in efforts to contain costs.

Intensive care units are expensive and some question their cost effectiveness. Twenty years ago, only 10% of U.S. hospitals with 200 beds or more had ICUs. Today 99% of hospitals have ICUs — totaling 68,500 beds. The cost for an ICU bed is approximately four times greater than costs for an ordinary hospital bed. ICUs account for about 20% of all hospital costs, or 1% of the GNP. It is estimated that 1.1 million patients with acute myocardial infarctions were treated in coronary care units in the United States in 1977. Since the advent of coronary care units, the mortality rate for acute myocardial infarction has declined from 25% to 15%.

I know of no health planner, governmental official, industry leader or critic of our health care system who was refused admission to a coronary care unit when seized with a crushing chest pain that brings perspiration to the forehead and a feeling of impending doom that eclipses all concerns about cost.

Coronary bypass operations were unheard of 20 years ago. In 1981, 159,000 such operations were carried out in the United States at a cost of over two billion dollars. It is impossible to estimate how many lives have been prolonged and how many people have been rehabilitated by this operation.

The health care bill paid by the American people has not only purchased a longer life but also a more productive, happier life — that intangible known as quality of life. Measles, mumps, whooping cough, polio, diphtheria, scarlet fever and tuberculosis have almost been eliminated. Thanks to modern eye surgery including lens implants, corneal transplants, vitrectomy and laser therapy, the blind are made to see and through the miracle of joint replacement the lame have been made to walk again.

Renal transplantation and hemodialysis now cost the nation over 1.5 billion dollars a year but more than 60,000 people owe their lives to these modalities which were considered investigational 20 years ago. What health planner or economist or bureaucrat would prefer to die of uremia rather than avail himself or herself of hemodialysis or renal transplantation? Although I have already acknowledged that some cost savings can be achieved by more appropriate utilization of hospitals and technical procedures and better fiscal policies in the management of hospitals, I submit that the American people have reaped tremendous benefit for their health care dollar.

In a very illuminating but so far unpublished treatise on "The High Cost?? of Health Care — Would You Like a Roaring 50s Contract?" Dr. Richard Sabransky only half facetiously calculated that Medical Mutual could offer a "Roaring 50s" contract, worth $8.30 per month in 1950 at $24.36 per month in 1982

dollars. Of course it would cover only those benefits that were included in the 1950 contract. He lists some 45 benefits that wouldn't be covered by the Roaring 50s contract because they weren't even in existence in 1950. Some of them are: care in surgical and medical intensive care units, coronary angiography, coronary bypass, CT scans, digital substraction angiography, hyperalimentation, cardiac rehabilitation, endoscopy, holter monitor, marrow transplant, cryosurgery and transluminal angioplasty. Who wants a Roaring 50s contract at $24.36 a month when for $68 a month you can get all of these additional benefits and more?

It is easy for the bureaucrat in Washington to write regulations that limit reimbursement to hospitals for Medicare patients by imposing DRGs. It is easy for utilization review organizations to decide in retrospect that a patient with abdominal or chest pain should not have been admitted to the hospital or that a patient who is under observation for a fever of unknown origin or changing neurologic signs is logging a "nonacute day." It is easy for the health planner or the leader of industry to tell us that we should practice more cost effective medicine — which means that we don't order any tests or procedures that are unnecessary but that we order all of those that are!

It is not so easy for a conscientious physician who has the responsibility and concern for his patients to decide which patient with chest or abdominal pain can be safely observed as an outpatient and which should be admitted to the hospital. It is not so easy to decide when an elderly patient with osteoarthritis and poorly controlled diabetes can safely go home following a bout of pneumonia, even though he or she has overstayed the allowance for the DRG. It is not so easy to decide when a patient with atypical chest pain should have a stress test. If the physician orders it and it is normal, he may be accused of being an "elaborate provider." If he doesn't order it, and the patient drops dead the next day, he may be sued.

Persistent efforts to contain the escalation of health care costs within the magic 10% of the GNP or within the limitations of the consumer price index will sooner or later impinge on quality of care.

A high technology, labor intensive service industry such as health care cannot be restrained to the CPI without eliminating services or rationing care by limiting access or providing two tiers of medical care which is repugnant to all of us.

I recall the early days of renal transplantation when reimbursement was not provided by the government or third party carriers. The board of governors at the Cleveland Clinic agreed to subsidize transplantation for 10 patients a year. A committee was appointed to decide which 10 of the scores of candidates for this procedure would be selected. All had end-stage renal failure and were doomed to die within a few months if they weren't transplanted because we didn't have adequate facilities for maintenance dialysis. I do not want to go back to those days. I, for one, do not ever again want to choose who shall live and who shall die. Yet rationing of care means just that, in England. Under their system of government medicine, it is an unwritten but self-enforced rule that patients over 65 years of age dying of renal failure are not offered maintenance dialysis.

I, for one, do not want ever again to choose who shall live and who shall die . . . yet rationing, of course, means just that.

When health care is rationed, who will decide which patients crippled with painful osteoarthritis will have hip or knee joint replacement and which will not? Who will decide which blind patients will have sight restoring cataract surgery or corneal transplants? Who will decide which patients with life-threatening arrhythmias will have pacemakers implanted and which will not? Who will decide which patients will be admitted to coronary or neurologic intensive care units and which are to be denied the chance to live in the name of cost containment?

Further breakthroughs in diagnostic and therapeutic technologies are jeopardized by unreasonably stringent cost containment efforts. What of nuclear magnetic resonance which promises to be greatly superior to the CT scan in some of its diagnostic capabilities? Are hospitals going to find it impossible to acquire NMR equipment? Positron emission tomography promises to open a new vista into the physiology and pathophysiology of intact human organs but will it be too costly? What of heart transplantation which is now where renal transplantation was 20 years ago? And the artificial heart? Shall further investigation of this be abandoned?

Research and development of new, less invasive methods of visualizing coronary arteries may eventually replace coronary angiography, and the laser may replace coronary bypass surgery; but research and development of this technology will be expensive, perhaps too expensive if we are to contain health care costs within 10% of the GNP advocated by some.

We must realize that our resources are finite and the time may come — or may already be here — when we simply can't afford the exploding technology which promises us an even healthier future. But that decision should be made by our patients, the American people — not by bureaucrats, industrialists and health planners.

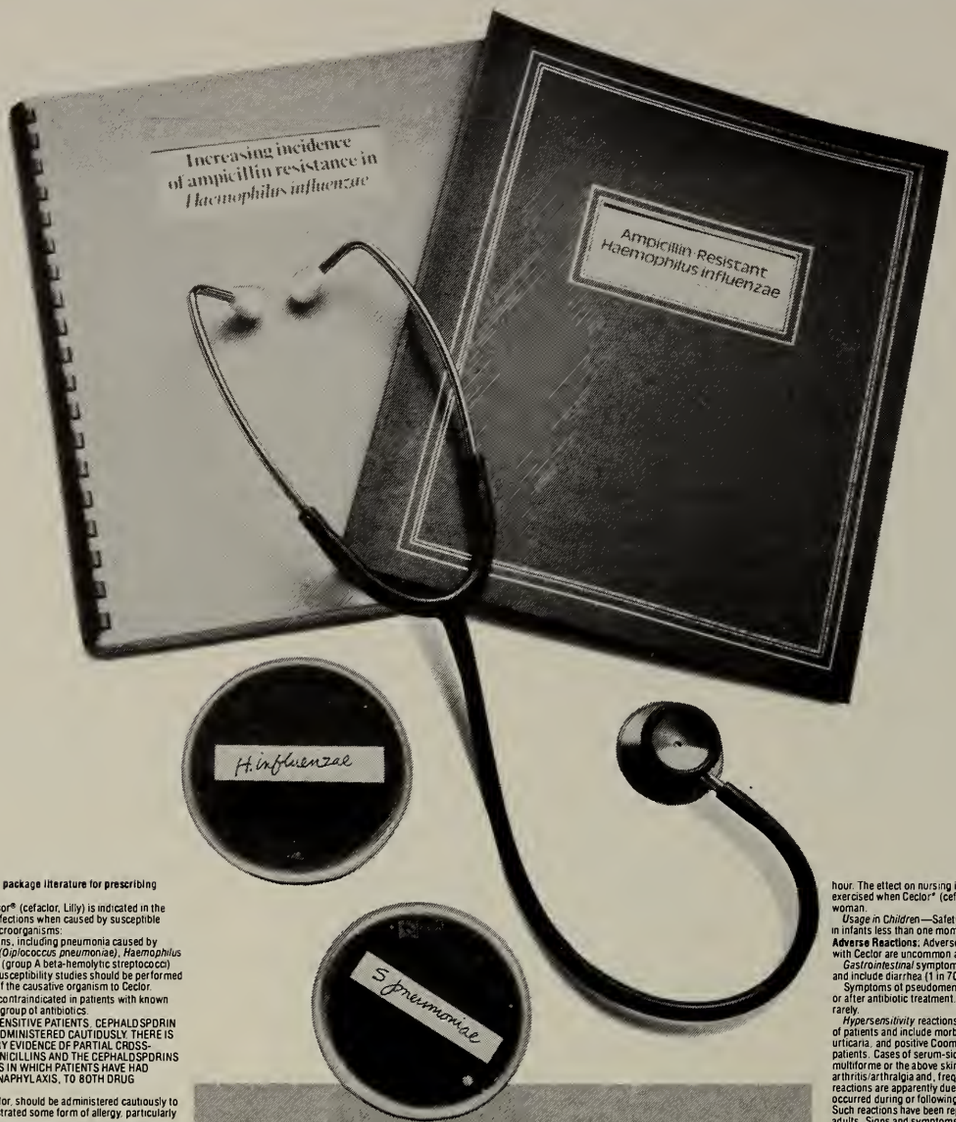
Our profession is under attack, our traditional modes of practice are being challenged and changed. The very existence of some hospitals is being threatened. The health care industry is at the crossroads.

But from every crisis arises an opportunity and a challenge and I am confident that the medical profession will seize this opportunity and rise to this challenge:

- We can and will practice more cost effective medicine without jeopardizing quality.
- We can and will work with hospitals to hold down costs by

continued on page 265

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor* (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGDT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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Colleagues In The News

Edited by Ginny Strawser

SAMUEL G. ADORNATO, MD, Youngstown, has been recently named clinical staff president for 1984 at St. Elizabeth Hospital Medical Center.

MICHAEL BARBER, MD, Cincinnati, has been named president of the medical staff at the Mercy Hospital of Hamilton for 1984.

LUDWIG M. DEPPISCH, MD, Youngstown, has accepted a new position as chief of the Department of Pathology and Laboratory Medicine for the Youngstown Hospital Association.

JOHN M. EVANS, MD, Cleveland, has been elected president of the medical staff at Fort Hamilton-Hughes Memorial Hospital for 1984.

ROBERT A. IRVIN, MD, Painesville, and **A.L. CEPULIS, MD,** Willoughby, were recently voted as "Physicians of the Year" by Lake County Memorial Hospital employees.

Lovshin Named President of State Medical Board



*LEONARD LOVSHIN, MD, Cleveland, was elected president and acting secretary of the State Medical Board for 1984. Dr. Lovshin has served as Chief of Internal Medicine, Director of Professional Staff Affairs and has been a member of the Board of Trustees at the Cleveland Clinic Foundation.



JOHN J. NEWTON, MD, Toledo, was recently elected president-elect of the Academy of Medicine. This is the second time Dr. Newton has been elected to this position, and is only the second person in the history of the Academy of Medicine to be elected to the position twice.

FRANK PAINO, MD, Cleveland, will accept another term as president of the medical staff at Fairview General Hospital for 1984.

The Board of Trustees Executive Committee of the Case Western Reserve University School of Medicine approved establishment of the **WALTER H. PRITCHARD, MD,** Professorship in cardiology. The professorship is in honor of the late Dr. Pritchard's distinguished 43 year career as an educator, practitioner, and researcher. The professorship will be held by a top ranking specialist, based at University Hospitals of Cleveland.

GABRIEL A. SABGA, MD, Elyria, has been named president of the medical staff at Elyria Memorial Hospital for 1984. Dr. Sabga has been with Elyria Memorial Hospital since 1962.

Lake County Medical Society has recently installed new officers for 1984. They are: **BELA BALLO, MD,** president; **QUENTIN J. SPITTLER, MD,** vice president; and **THOMAS LEININGER, MD,** secretary-treasurer.

Clark County Medical Society has installed new officers: **JOEL VANDERGLAS, MD,** president; **DENNIS SULLIVAN, MD,** president-elect; **PAUL ANDORFER, MD,** secretary; and **SALLY ABBOTT, MD,** treasurer.

The St. Joseph Riverside Hospital of Warren has elected new officers. They are: **MICHAEL J. CASALE, MD,** president; **JOHN A. GRIMA, MD,** vice president; and **R.D. HECKEL, DDS,** secretary-treasurer.

The Trumbull Memorial Hospital in Warren has installed new officers. The new officers are: **T.W. SOBOSLAY, MD,** president; **C.A. ANDERSON, MD,** vice president; and **E.B. SALERO, MD,** secretary-treasurer.

The Northwestern Radiological Society has installed new officers for 1984. The elected officers are: **R.W. SIDERS, MD,** president; **G.B. MEHTA, MD,** President-elect; and **THOMAS N. SARDELIS, MD,** secretary-treasurer.



ROBERT J. WHITE, MD, Cleveland, was elected a member of the Knights of Malta. Dr. White is Director of Neurological Surgery at Cleveland Metropolitan General Hospital and professor at Case Western Reserve University Medical School.

Physician-researcher faces conflicts, competition

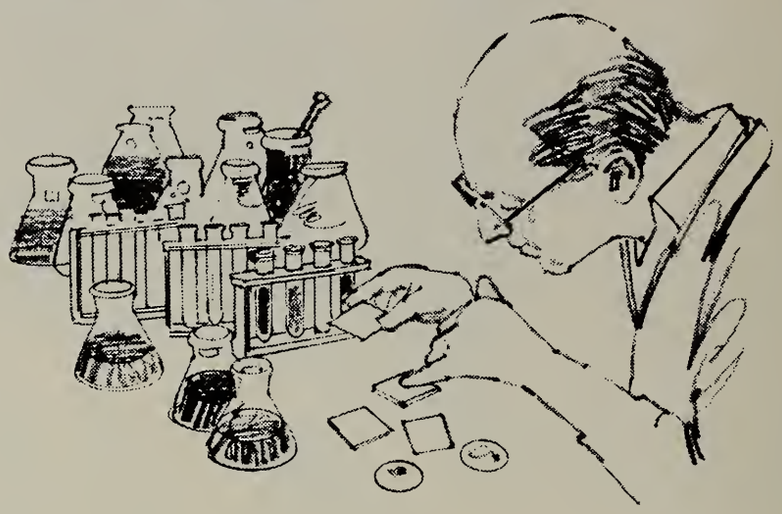
A decline in the number of practicing physicians who also are involved in research and who are not linked to universities may be, in part, due to the difficult and sometimes conflicting duties the doctor-researcher faces in his/her work. A recent article in the *Wall Street Journal* highlighted that problem in a front page story on Anthony Breuer, MD, one of the few Ohio physicians to choose that dual role.

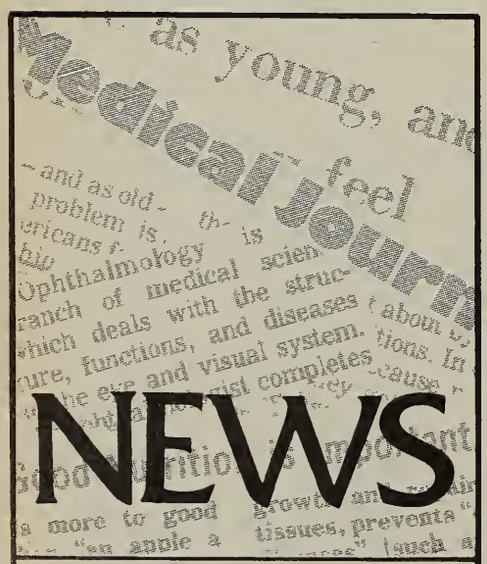
Dr. Breuer gave up most of his successful clinical practice around two years ago in order to undertake a research project on amyotrophic lateral sclerosis (ALS) — Lou Gehrig's disease — the article states. He was awarded a three-year $107,000 grant from the National Institutes of Health (NIH) to support his work at the Cleveland Clinic, investigating the role of faulty chemical traffic within cells in fatal nerve disorders such as ALS. He also sees patients afflicted with ALS at the clinic.

While the practicing physician brings many valuable insights to the field of research — "medical breakthroughs often have resulted from the relevant questions physicians raised about diseases they treated every day" — there are also some disadvantages, the article points out.

"It's hard to be in the middle of a research problem and have to break off to take a call from Mrs. Brown who is crying on the phone because her husband's dying," Dr. Breuer is quoted as saying. "And it's hard to go on rounds and give each patient your total attention and not be distracted by data turning over in your brain."

Another problem part-time researchers like Dr. Breuer face is competition for grants which increasingly are going to scientists who are not practicing physicians, according to the article. In addition, "Requests for grants have nearly doubled in the past decade, while the NIH funds have grown by only about a third. That has left the NIH financing over a third of the projects it recommends for support, compared to 75% two decades ago," the article says.





a compilation of the latest developments, reports and products of interest to physicians.

edited by Susan Porter

Staging suggested for DRGs

A "staging of disease" approach to classifying hospital admissions and care would provide hospitals with a more equitable system for reimbursements under the new Diagnosis Related Grouping (DRG) prospective payment system, now in force for Medicare patients.

A recent article in the *Journal of the American Medical Association (JAMA)* says that the severity of the defined illness must be taken into account if institutions, whose patients happen to be sicker than the average, are not to be unfairly penalized under DRGs.

The DRG system, at present, reimburses hospitals a fixed fee which is based on the average cost of treating a patient in that particular diagnosis-related group, regardless of the number of days hospitalized or the extent of the treatment. Those hospitals which can treat the patient for less, make money; those whose costs are higher than the reimbursement must absorb the cost.

Many critics of DRGs point out that the incentive, therefore, is to undertreat the patient, while the ideal case — financially for the hospital — is that where the patient dies shortly after being admitted. Also, hospitals now face an incentive to admit only patients with the least severe illnesses within a DRG category.

Researchers from Jefferson Medical College, therefore, suggest in their article that DRGs include four stages of severity: "conditions with no complications or problems of minimal severity; problems limited to an organ or system; multiple site involvement, generalized systemic involvement, poor prognosis; and death."

They also point to the need for more specific definition of diseases at the starting point. Diabetes mellitus, for example, is not a single disease but a family of diseases, including hyperglycemia, diabetic acidosis, diabetic retinopathy, diabetic coma and azotemia secondary to renal damage.



International perspective would benefit medicine

Medicine could benefit greatly — both in the U.S. and in other countries — if more physicians adopted an "international" perspective, according to a series of articles which recently appeared in the *Journal of the American Medical Association.*

There are political, humanitarian and even scientific reasons why doctors need to think in terms of world health, rather than simply national health in the practice of their professions, the series indicates.

Articles point to the low percentage of health manpower the U.S. provides other countries, recent efforts by China to adopt a westernized approach to medical education, and even infectious diseases Americans may contact abroad as reasons physicians should look beyond the boundaries of the U.S. in their work.

Researchers at John Hopkins University point out that Cuba provides almost a fourth as many health professionals to international health activities as the U.S., yet is less than one twentieth in size. "Our balance of payments of physicians in this country is heavily positive with a ratio of almost 50 to one of physicians having immigrated vs. those sent here from abroad," comments *JAMA* editor George D. Lundberg, MD. "We, as a profession, should cultivate a mind-set that looks to all humanity."

In China, a nationwide entrance exam has been adopted for all medical university applicants, a complete reversal over policy practiced less than a decade ago when "to encourage cooperation rather than competition, examinations were rare, even during school terms," a second article says.

This westernized approach to medical education may serve as "a harbinger to more free academic exchange with the other major communist power," suggests one researcher and traveler to China who calls the free exchange of information and students a fundamental unit of peace. "An unarmed quarter of a million university-level students integrated into each other's society would be agents of security for both sides," he says.

JAMA is now printed in Chinese and distributed throughout the country.

Each year, an increased number of Americans travel abroad; a third article focuses on "mysterious" infectious diseases they may bring back. One problem in diagnosing these diseases is that physicians fail to ask an ailing patient about his/her recent whereabouts.

"Many physicians are not comfortable with this responsibility because they are trained quite naturally to deal with the common disease in their own country, not diseases that are often called 'exotic,' " say researchers from the Center for Disease Control. Patients, also, often consider their recent travel irrelevant and therefore fail to mention it unless asked.

"Physicians should not succumb to this error," the article says. "Most of the infectious diseases that travelers acquire are relatively easy to diagnose — provided one has thought of them."

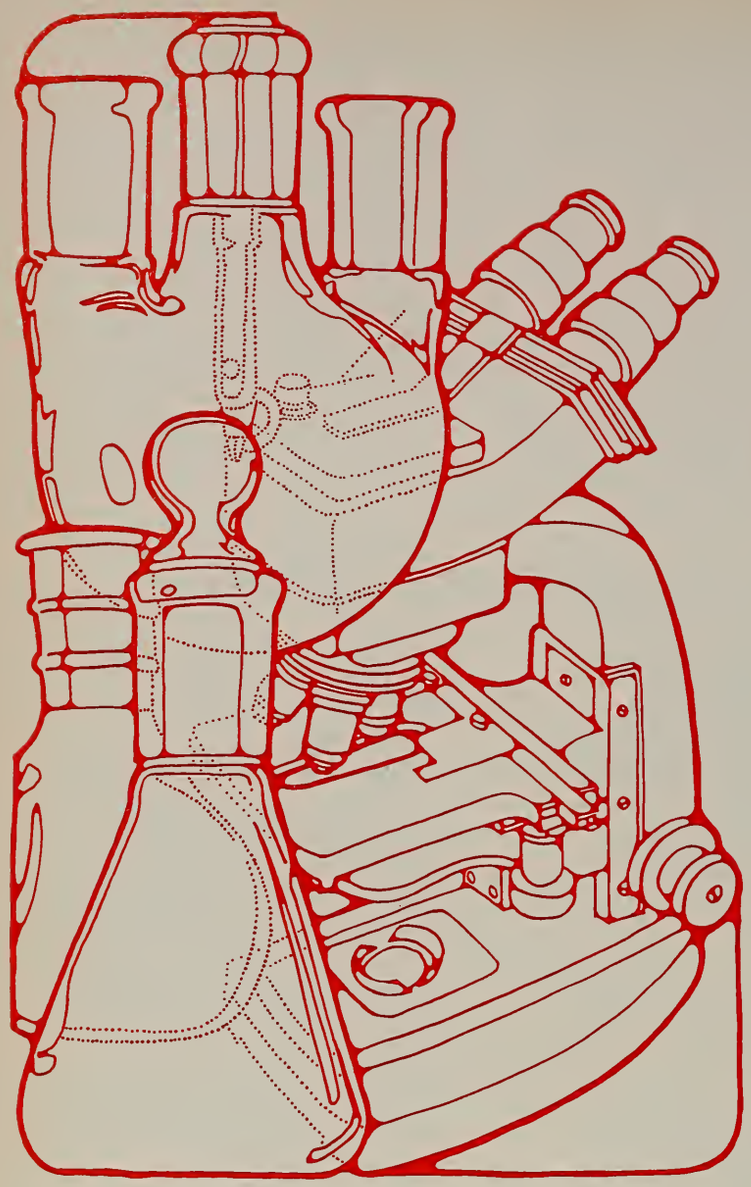
British system has pros/cons

No one in England is without a doctor and because physicians are paid by the government, all patients get care, regardless of their ability to pay, two residents in the Mount Carmel Family Practice Program discovered recently on a work-study trip to Great Britain. However, an article in *Family Practice News,* a quarterly publication of the Ohio State University Department of Family Medicine and Affiliated Family Practice Residency Programs, lists more "inferior points" than "superior points" in an article describing their experiences.

All patients in England are assigned to a general practitioner and they must go through him/her in order to see a specialist, according to the article. Rated "superior" were a more advanced system of care and housing for the geriatric population, the standardization of patient charts, and a comprehensive package of retirement and disability benefits provided doctors by the government.

The residents, each of whom worked in several different practices in several different communities in England during their stay, also noted low pay for doctors, long waits to see specialists, long waits for elective surgery and too few renal dialysis machines. In addition, they saw extensive use of hospital trainees and "health visitors" in the British health care system, and they perceived an overall poor image of the health care system by the public.

Also, because doctors are required to make house calls upon a patient's request — even if that patient is able to come to the office — "house calls have become a highly inefficient use of the general practitioner's time," the article points out.



The Environment of Medicine

A Report from the AMA's Council on Long Range Planning and Development

Editor's Note:

In December, 1983, the American Medical Association's Council on Long Range Planning and Development presented its latest summary report on the environment of medicine. The objective of the report is to provide information which could be helpful to both individual physicians and organized medicine in planning for the future.

"It has become apparent," the Council notes, "that the future of the profession, of organized medicine and of medical care in this nation depends on our ability to anticipate and plan for changes in the environment of medicine."

In its report, the Council attempts to identify and analyze the variety of forces which have the potential to cause significant changes in the practice of medicine. And there will be changes.

"If there is one immutable law, it is that no individual or organization can be protected from change" (and) ". . . some current developments may not be beneficial to patients and physicians. Unless the profession is successful in planning for and shaping the environment of medicine, the future could be less encouraging."

As you read the following summary of the 100-page report which outlines the medical system in terms of economics, demographics, manpower, structure, and attitudes held by physicians and the public, the AMA Council urges that "you keep in mind that success in responding to the environment within which the profession must provide its services may be as important to health in America as any challenge we, as a profession, have ever faced."

As future space permits, the Journal will carry selected excerpts from the full report. For a copy of the entire report, write Council on Long Range Planning, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610.

Under the Constitution and Bylaws of the American Medical Association, the Council on Long Range Planning and Development is charged, in part,

> **to study, or cause to be studied, anticipated changes in the environment in which medicine and the Association must function, collect relevant data and transmit interpretations of these studies and data to the Board of Trustees for distribution to decision-making centers throughout the Association, and submit reports to the House of Delegates at appropriate times.**

In fulfilling this charge, the Council has developed a number of reports to the AMA House of Delegates. In 1979, the Council embarked on an effort to develop a summary report on environmental trends. This effort culminated in a report which identified implications for organized medicine that could result from emerging trends

in the environment. The report was widely distributed throughout the federation under the title, "The Environment of Organized Medicine."

In 1982, the Council began to update and expand its summary report on environmental analysis. The Council had two objectives in this undertaking:

- to provide physicians with information that could help them better serve their patients; and
- to develop background information and analysis that might help both individual physicians and organized medicine plan for, adapt to, and even capitalize on environmental change.

To achieve these objectives the Council studied seven major areas of the environment, including:

- The Economy;
- Demand for Medical Care Resources;
- Supply of Medical Care Resources;
- The Economics of Medical Practice;
- The Structure of the Medical Care Sector;
- Changing Roles in the Health Sector; and
- Trends in Public and Physician Attitudes.

The following is a brief overview of the Council's findings on these topics.

The Economy

Trends in the general economy can have significant impact on individual physicians and medical organizations. Since 1980, the economy has experienced two recessions. Although the recession of 1980 was brief, the recession of 1981-82 was the most severe economic downturn since the depression of the 1930s. The current consensus among major forecasting services is that 1984 will see:

- a 4.8% increase in inflation-adjusted GNP;
- an increase in consumer prices of 4.9%;
- an unemployment rate of 8.9%; and
- an interest rate on Treasury bills of 8.0% to 8.3%.

In essence, the forecast is that the economy will continue to recover through 1984. Interest rates are likely to remain high while inflation is likely to increase, but remain below double-digit levels.

Overall, the improving economy suggests that conditions should improve for physicians and organized medicine. However, some geographic areas will be slow to recover from the recession. Physicians in these areas will probably continue to experience economic difficulties. High interest rates will continue to be a problem for young physicians establishing private practices and for students seeking to borrow funds to finance their medical educations.

Demand for Medical Care Resources

The demand for medical care resources is closely related to the demand for medical care services; factors which increase the demand for medical services also increase the demand for medical resources. In general, the slower the population growth rate, the slower is the growth in demand for medical care and medical care resources. In recent years, the population growth rate has been decreasing; projections by the Census Bureau indicate that the population growth rate is likely to slow even further.

The age distribution of the population is also strongly related to the demand for medical care. The age distribution of the population has been changing for decades and will continue to change as the "baby boom" generation grows older. This situation is likely to create fluctuations in the demand for physicians' services, particularly in the areas of obstetric care, pediatric care, and geriatric care. Overall, expected changes in age distribution are likely to increase the demand for medical care resources and, thereby, increase pressures on costs.

The characteristics of health insurance coverage also influence the demand for medical care. Over the past several decades, the extent of health insurance coverage increased, which tended to increase demand. However, the characteristics of health insurance coverage are currently changing in ways that are likely to decrease the demand for medical care and medical care resources.

Given the likely trends in all the factors that influence demand, it appears that demand for medical resources will continue to grow, but more slowly than in recent decades. Any growth in demand implies that health care expenditures will continue to be an important issue facing organized medicine. However, given the expected rapid growth in health professionals, slow growth in demand also implies an increasingly competitive environment for physicians.

Supply of Medical Care Resources

The various categories of medical resources have been growing at different rates over the past decade.

- For a number of years, the supply of physicians has been growing faster than the population. Recent projections indicate that the supply of active physicians will continue to increase faster than the general population.
- Since 1972, the number of community hospital beds per capita has stayed relatively constant. Although there are no firm forecasts, many analysts believe that increasing competition and restrictive reimbursement for Medicare patients will lead to consolidation in the hospital sector and a reduction of hospital beds per capita.
- The supply of other health professionals has been growing rapidly over the past decade. Projections indicate that the supply of other health professionals will continue to grow rapidly between now and the end of the century.

The slow rate of growth in hospital resources suggests that the issue of access to hospital-based medical resources will intensify for both individual physicians and organized medicine. Further, unless the demand for medical care resources grows more rapidly than anticipated, the growing supply of health professionals will create a more competitive environment for physicians. Through its "Competition Action Plan" (BOT Report E, I-82), the AMA has initiated a series of activities to help physicians adjust to competitive forces.

The Economics of Medical Practice

The environmental factors which have influenced the demand for and supply of medical care resources have also affected the economics of medical

practice. Trends over the past decade include;

- the rate of increase in the typical physician's income has been slightly less than the overall rate of increase in consumer prices;
- the practice expenses of the typical physician have been rising faster than the overall rate of inflation;
- the rate of increase in expenses for professional liability insurance has exceeded the overall rate of increase in practice expenses; and
- the rate of increase in physicians' fees has slightly exceeded the overall rate of inflation.

Although these trends indicate that changes have been occurring in the economics of medical practice, the typical physician does not appear to have experienced a substantial change in real income over the past 12 years.

Several emerging trends suggest that the economic characteristics of medical practice could change in the near future. These trends include:

- increasing economic (price) competition in the physicians' services sector;
- expansion of investor-owned organizations in the health sector;
- changes in the Medicare reimbursement system for hospital services and, perhaps, for physicians' services;
- new entrepreneurial opportunities for physicians; and
- changing relations between hospitals and physicians.

A more competitive environment may change the types of services physicians need from organized medicine.

The Structure of the Medical Care Sector

The structure of the medical care sector is undergoing rapid evolution. Significant trends in the structure of *medical practice* include:

- an increasing proportion of physicians practicing in a group setting;
- medical practice has become increasingly integrated financially with the hospital; and
- a small, but growing number of physicians provide their services in alternative delivery systems, such as HMOs and free-standing clinics.

The structure of the *hospital sector* is also undergoing evolution. Trends include:

- the hospital sector is undergoing consolidation — the number of hospitals is changing only slightly, while hospital size is increasing;
- managerial control of hospitals is changing — the number of hospitals in multi-hospital systems is increasing and the influence of for-profit hospitals is increasing; and
- more and more hospitals are expanding into areas of health care delivery not traditionally served by hospitals.

Reimbursement by diagnostic related groups (DRGs) for Medicare patients is likely to accelerate structural change in the hospital sector.

The private *health insurance sector* is also undergoing structural change. Independent plans are gaining market share at the expense of insurance companies and Blue Cross-Blue Shield plans. A growing number of corporations are "self-insuring" for the medical expenses of their employees. These companies are experimenting with methods to reduce the costs of providing health insurance coverage to their employees.

It is likely that the changing structure of the health care sector will alter the environment in which physicians provide their services. First, the structural changes will further increase competitive pressures on physicians. Second, an increasing proportion of physicians are likely to become employees of health care institutions. Third, pressures will intensify on physicians to consider economic factors in making medical decisions.

Changing Roles in the Health Sector

The increasing costs of health care over the past several decades have resulted in some changes in the roles of the participants in the sector.

- *Government* has adopted a role of intervention in order to alter the economic performance of the health care sector.
- *Business* has become much more active in programs to contain business expenses related to health insurance coverage for employees.
- *Organized Labor* has continued to seek full health insurance benefits for workers, but has recently become more active in efforts to contain health care costs.
- *Third Parties* have become more aggressive in containing health care costs in order to reduce the rate of increase in health insurance premiums.
- *Hospitals* have become more active in containing costs. The increasing level of competition and the implementation of reimbursement changes for Medicare patients have given hospitals strong incentives to contain hospital costs per patient.
- *Patients* have become more careful consumers of health care, in part, because of the rising costs of care.

Organized medicine has also become more active in socioeconomic aspects of medicine as the intensity of discussion on health care costs has increased. A 1983 AMA survey found that 113 medical societies are currently involved in health care coalitions. The AMA has long been involved in promoting cost-effectiveness in health care and in monitoring developments in the socioeconomics of medical practice.

In essence, the major participants have become more active in attempting to modify, to some degree, the health care system in order to restrain costs. This change in roles has probably increased the potential for structural change of the health care system. The potential for controversy over the performance of the system has also increased. Further, the focus on reducing health care costs may create pressures that will threaten the quality of care. Physicians and organized medicine will have to continue to stress the importance of maintaining quality.

Trends in Public and Physician Attitudes

The AMA has been tracking physician and public attitudes on key health care issues for over a decade. The Council found that both physicians and the public believe that "cost" is the primary issue facing health care today. Another important finding of the Council's analysis is that the opinions of physicians and/or the public differ on three issues:

- methods to contain health care costs;
- the supply of physician manpower; and

- **the level of competition in medicine.**

These three issues represent potential dilemmas for organized medicine because organized medicine must respond to each, but any policy position on them is likely to be opposed by segments of the public or physician populations.

Summary of Common Themes

Several common themes run through the environmental trends outlined above and discussed in detail in the other chapters of this report.

Theme 1: The environment of medicine is becoming more dynamic. Financial pressures, as well as media attention to the medical care sector, have created an impetus for change in the environment. A general sense is emerging that "the health care system must be changed quickly." Government, business, and to some extent, the public are ready for experimentation with the medical delivery system. The speed with which DRG reimbursement of hospitals was implemented is an example of the increasingly dynamic character of the policy environment.

Theme 2: Cost pressures are the principal driving force underlying change in the medical care environment. Almost all the current trends in the environment can be traced, directly or indirectly, to the "cost" problem. It is likely that rapid environmental change will persist until the cost issue is resolved in some manner. The key question is what type of change in the "system" will preserve the most crucial features of the current delivery system and also contain costs?

Theme 3: Governmental initiatives are the most likely source of immediate change in the environment of medicine. The combination of governmental concern over rising health care costs and governmental power to alter the health care financing and delivery systems through legislation could lead to substantial changes in the environment of medicine in the near future.

Theme 4: Changes in medical technology are the most potent long range force for change in the environment of medicine. Changes in technology can cause dramatic shifts in demand for medical care and can also radically increase or decrease costs.

Theme 5: There is uncertainty about trends in some of the fundamental forces that will shape the future environment of medicine. Little is known about the implications of future trends in medical technology. Further, there is uncertainty about future trends in the demand for medical care resources. It is possible that demand will grow more slowly than supply, or demand will grow at the same rate as supply, or demand will grow more rapidly than supply. Each of these three alternatives holds vastly different implications for the future environment of medicine. Many of the implications identified in this report are based on the *assumption* that demand will grow more slowly than supply. Although there is support for this view, that support is not conclusive.

Theme 6: The potential for economic dislocation in the medical care environment is increasing. The changing demographic characteristics of the population and advances in medical technology have the potential to induce shifts in demand both geographically and across specialties. Temporary shortages and surpluses are likely to arise and create distress for both physicians and the public.

Theme 7: There is a growing sense of economic uncertainty in the medical care sector. Environmental trends and proposed changes in the financing of medical care pose potential economic "threats" to physicians, hospitals, and allied health personnel. In part, this perception of economic uncertainty can be traced to increased media attention to health policy issues. Whether or not this sense of uncertainty is justified, it has become an important aspect of the environment of organized medicine.

Theme 8: The issues arising in the environment of medicine are increasingly dictated by forces at work in the general society. The aging of the population and the poor performance of the economy are creating pressures on governmental budgets. These financial pressures cause governments to search for ways to alter the economic performance of the health sector. Further, international competition is forcing U.S. firms to cut back on the health benefits they provide to their employees.

Theme 9: Health policy issues are becoming more politicized. The attempts of the Reagan administration to shift responsibility for health programs to the states, and the resistance of the states to this idea, have injected political philosophy into discussions on health policy. The economic problems of the poor, elderly, disadvantaged, and unemployed may again raise concerns about "access to medical care."

Theme 10: Changes in the environment of medicine may lead to unexpected divisions and alliances on health policy issues. The intensity of economic competition in the health sector is likely to continue to increase because of the increasing supply of health personnel and because of changes in the financing of care. Intense economic competition usually rewards some individuals and groups and penalizes others. Consequently, unexpected realignments on policy issues could occur.

Much of the analysis contained in this report suggests that the environment of medicine is likely to undergo further evolution in the near future. It appears that this evolution, if it occurs, is likely to involve some restructuring of the medical care financing and delivery systems. But, given the uncertainties about the magnitude and direction of several key environmental trends, the development of a specific forecast of the future environment of medicine is very difficult. *Therefore, the AMA's Council on Long Range Planning and Development has not attempted to make a prediction on the mechanisms through which medical care will be financed and delivered in the future, except to suggest that change is likely.* Rather, the Council has attempted to provide background information and

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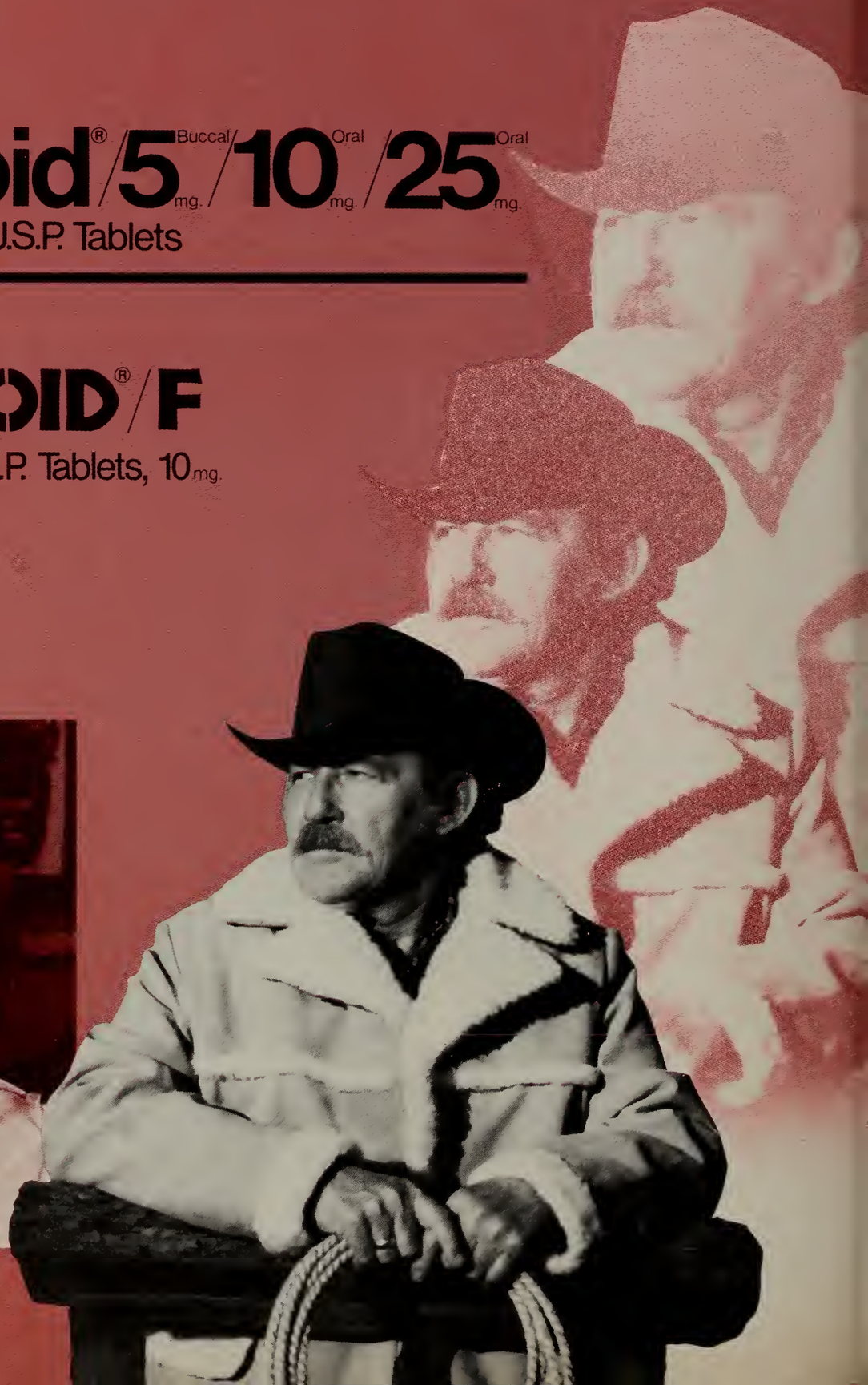
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How Ohio hospitals are coping with DRGs

By Susan Porter

For months, hospital newsletters and bulletin boards have warned of their coming, and daily newspapers have flashed their initials in headlines as ominous as "Days of DRG arrive." Special CME classes have been held to explain them, coordinators have been hired to oversee them, task forces have been formed to monitor them and computer systems have been purchased to keep track of them.

Yet until January 1, when most Ohio hospitals began a new fiscal year under the new Diagnosis Related Grouping prospective payment system for Medicare reimbursement, DRGs were simply an often used but still confusing acronym, regarded by legislators as a "Divine Redeeming Grace" for the troubled Medicare system, but dreaded by hospital administrators as "Disasterous Regulations Galore."

Several months following the formal implementation of DRGs, many hospitals are still uncertain about their ramifications, although some are experiencing major problems and several "rural" Ohio hospitals were taking legal action as the *Journal* went to press in mid-February. Even well-established institutions in major cities are expressing uncertainties about both the short- and long-term effects DRGs will have on their establishments.

"For our hospital, DRGs have been in effect for only a month," said Thomas Gretter, MD, quality assurance officer for the Cleveland Clinic in a February interview. "So it's still too early to tell exactly what the impact is going to be, although it's true — they are definitely having an impact."

Part of the problem, Dr. Gretter explains, is that the final regulations for DRGs were not released until January 3, 1984, leaving hospital administrators guessing until the last minute what the actual reimbursements would be. Another difficulty with predicting their impact is that hospitals have no track record under DRGs and so, "We have to make our projections based on old data," he says.

This is further complicated by what Dr. Gretter calls "a changing medical scene." He explains, "A hospital's population base is constantly shifting. The population is aging. There's more to a hospital than Medicare, but everyone else (third party payers) is looking at scaling back, too."

Therefore, it becomes difficult to separate changes brought about by DRGs from those that have come about by numerous other efforts to cut health care costs. Still, Dr. Gretter feels relatively comfortable forecasting that hospitals like the Cleveland Clinic, which he says have always attempted to be cost efficient, "are going to be all right — that is, we aren't going to *lose* money."

To date, the emphasis on DRGs at the Clinic has revolved around educating staff members about the gathering and correlating of information — "the importance of accurately determining and documenting the primary diagnosis and of supporting it throughout the document." Otherwise, says Dr. Gretter, "We've told our physicians to continue practicing high quality medicine just as they always have. Our primary goal is still quality care. We're concerned that if we start putting the cost of what we're doing before the quality, the quality may suffer."

Because the Clinic has "a fair amount of computer capacity," according to Dr. Gretter, a big part of the implementation of DRGs has been the shifting of personnel from the financial department into information retrieval services. However, not all Ohio hospitals have the on-line capabilities of a large, nationally-known health care facility in a major metropolitan area. Thus, many smaller institutions have had to go to some expense to purchase equipment and hire personnel to handle DRGs.

At Blanchard Valley Hospital in Findlay, for example, a DRG coordinator has been appointed to consult with physicians and assist them in filling out forms and filing claims. According to William Ruse, president, the hospital also has an in-house task force of physicians and other staff members monitoring the impact of DRGs and suggesting ways to improve cost effectiveness.

"We have started to publish a special DRG bulletin on a periodic basis," says Ruse, "to update our staff members on new developments and to provide them with 'tips for survival.' " But even survival tips are not likely to solve a major problem Blanchard and 71 other hospitals in Ohio currently face under DRGs. These hospitals, comprising over one-third of the hospitals in the state, lie in what the U.S. Census Bureau has classified as "rural" counties, a designation that places them at a costly disadvantage where DRGs are concerned.

The issue revolves around the "very

complex formula" used to compute DRGs, according to John Callender, vice president for financial services for the Ohio Hospital Association, who admits, "We definitely have an urban/rural problem." That formula currently breaks the 50 states into nine different regions (Ohio is in Region 4, East North Central) for reimbursement purposes. By 1987, all hospitals in the country will be reimbursed according to standard national rates; however, during the interim period, reimbursements are made according to a combination of actual hospital costs, regional rates and national rates, says Callender.

In addition, within each region there are both rural and urban rates; these are figured by combining labor-related and nonlabor-related components, the former taking into account local wage indexes. As can be seen in Figure A-1, reimbursements for hospitals in rural areas in all regions are substantially lower than the urban reimbursements. A smaller wage index set for all rural areas further diminishes their returns. By 1987, when the nine regions are dissolved and national rates are in place, the urban/rural differential will be even greater, says Callender.

At present, hospitals located in any county that is not in what the U.S. Census Bureau defines as a Metropolitan Statistical Area (MSA) as defined by population and labor figures, are automatically considered "rural," regardless of the hospital's size, the types of services provided or its proximity to an MSA. This puts hospitals such as Northern Columbiana County Community Hospital located in "rural" Columbiana County but just 300 yards from the Mahoning County (Youngstown MSA) line at a notable disadvantage, says Callender. By 1987, the hospital will be paid an average of $1,000 per DRG less than its urban neighbors. "And the cost of doing business and rendering health care does not change by moving 300 yards," he says.

The urban/rural differential is based on the assumption that the cost of living in rural areas has traditionally been less; therefore the cost of providing health care in those areas should be less, as well. But this is not necessarily the case, Callender and other Ohio hospital administrators contend.

"The fact that one hospital is in an urban area and another is in a rural area may or may not have anything to do with the quality of services provided or the cost of providing those services," says William VanGieson, president of the Bethesda Hospital in Zanesville, also classified "rural."

In Zanesville, for example, hospitals compete with those in the nearby Columbus MSA for both patients and personnel. "We have to be as close to Columbus in salaries as possible," he says. Similarly, the services the hospital provides are comparable to many of those in the neighboring MSA. "We're obviously not a University Hospital or a Riverside — we don't do transplants or open heart surgery. But we're a fairly sophisticated medical center and we do most other things, including dialysis and neurosurgery." Yet his hospital will receive $3 million fewer dollars in 1987 due to its "rural" designation.

The urban/rural differential is based on the assumption that the cost of living in rural areas has been less, therefore the cost of providing health care in those areas should be less . . . but this is not necessarily the case

Unfortunately, those hospitals which feel they have been wrongly categorized have no recourse, says Callender, since the Secretary of the Department of Health and Human Services has chosen not to develop an exception process to handle such grievances. Thus, the Ohio Hospital Association is suggesting member "rural" hospitals take their concerns to their local congressional representatives. Some are going even further.

Ruse of Blanchard Valley Hospital already is working with legislative representatives from Findlay in hopes of "getting legislation introduced to provide some relief for rural hospitals." His hospital is sandwiched between two urban counties and only 18 miles from a 42-bed hospital with an urban designation. "Yet by 1987, there will be a 35% differential between what they get and what we get," under DRGs, he says.

Blanchard also is one of only 149 rural hospitals in the country with over 200 beds, according to Ruse, and these larger hospitals tend to provide many of the more sophisticated, high cost services. Therefore, he is hoping to join in a coalition of these hospitals to lead a national effort to grant them exemption from the "rural" designation.

But smaller rural hospitals in Ohio are equally unhappy with their lower paying status and most feel the fairest move would be to eliminate the differential altogether. "If it is the policy of the federal government to set and pay a prospective price, then that price needs to be determined," says Bob Morrison of Mercy Memorial hospital in Urbana who is leading a group of 15 Ohio hospitals hoping to accomplish this task. "Those hospitals efficient enough to operate for less should be able to use their extra funds to improve or extend their services. Those who operate above the cost will have to figure out ways to better manage their costs. But we don't feel it's fair for some hospitals (rural) to be locked into some kind of an historic average. It's like saying minorities historically have worked for less money; therefore, they should continue to be paid less."

According to Morrison, Mercy Memorial in Urbana will be receiving 44% less in reimbursements than hospitals in the neighboring Dayton/Springfield MSA. The difference will total over $1 million a year by 1987, he says. "Some hospitals are looking at as much as $7 million a year," he continues. "And these are bottom line — profit vs. loss — dollars."

The problem goes beyond the dollars, however, Morrison says. It also threatens to hamper any growth opportunities for hospitals like the

68-bed Mercy Memorial. "When we talk about community service and outreach programs — programs that often generate an increased patient flow — the urban institutions are going to have substantially more money to work with. They will be able to use their increased revenues to develop satellite services and ambulatory care centers in *our* areas. Whenever you have one institution getting 44% more than another, that (former) institution has a real competitive edge."

Thus Mercy recently joined 10 other "rural" Ohio hospitals in filing suit in the U.S. District Court in Columbus, asking the court to rule the urban/rural designation unconstitutional. Other hospitals across the country are expected to follow suit before "the year of the DRG" is over.

To date, this aspect of the new DRG system has gained the greatest attention. However, Callender and others already are observing additional side-effects from Medicare's quick-fix treatment program from which both urban and rural hospitals may suffer.

One is the failure of the DRG system to take into account a hospital's "intensity index." Hospitals serving large numbers of sicker-than-average patients under Medicare will be hardest hit and may eventually be forced to close their doors; this could mean the end for some large, inner-city facilities that tend to attract this type of patient, as well as smaller hospitals which operate at close margins. Says VanGieson, "You can only afford to lose so much money on so many patients."

Also, the system fails to leave a margin for investment into new technology, says Callender. "Unless a hospital is able to show it can render care at below DRG rates, it won't be able to borrow money because it will be considered a bad financial risk. So it won't be able to buy expensive, high-tech equipment."

This year, says Callender, most Ohio hospitals will survive DRGs, largely because the formula is still heavily weighted towards hospital costs and regional rates, the latter among the highest in the country. "But our projections show that as we blend into the national rates, hospitals are going to have to reduce their costs by 1½% per case, each year, in order to break even in 1987. You begin to realize that what you're looking at is a very flat rate of income."

FIGURE A-1
Adjusted Standardized Amounts (Labor/Nonlabor)

REGION	URBAN		RURAL	
	Labor Related	Nonlabor Related	Labor Related	Nonlabor Related
1. New England (CN, ME, MA, NH, RI, VT)	2342.75	638.28	2003.02	484.24
2. Middle Atlantic (PA, NJ, NY)	2106.03	630.78	1993.64	491.11
3. South Atlantic (DL, D.C., FL, GA, MD, NC SC, VA, WV)	2192.95	584.52	1803.89	408.07
4. East North Central (IL, IN, MI, OH, WI)	2340.95	680.40	1959.42	457.10
5. East South Central (AL, KY, MS, TN)	1990.97	520.25	1819.64	381.83
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	2283.48	605.28	1828.58	392.30
7. West South Central (AR, LA, OK, TX)	2146.37	572.51	1762.03	380.42
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2108.90	607.69	1826.56	426.96
9. Pacific (AK, CA, HI, OR, WA)	2219.82	711.58	1908.93	497.87

Urban and Rural rates are determined by adding the labor related and non-labor related rates in each region. The rates in the East North Central Area, for example, are $3021.35 in the Urban Areas and $2416.52 in the Rural Areas.

Source: Health Care Financing Administration, 1983

It's not just DRGs that are contributing to the leveling off; rather as Dr. Gretter points out, DRGs are just one component of "a changing medical scene" that promises to leave no part of the health care delivery system untouched.

"Already we are seeing a significant reduction (in patient load) in our average daily census," says Ruse, "and it's not all Medicare patients. There's been a major turn-around in people's perceptions of their health care needs. It's like the entire population is starting to ask, 'Do I really need to go into a hospital, or can I have this done on an outpatient basis?' "

From a health care cost standpoint, says Ruse, this marks "a very positive trend" — a definite sign that DRGs and other cost-containment activities are working. But from a hospital's point of view, "this kind of shift can be, financially, very difficult." **OSMA**

Susan Porter is Assistant Editor of the Ohio State Medical Journal.

Second Opinion

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more appropriate utilization practices.

- We will continue to practice self restraint in our fee schedules.
- We will not let quality fall victim to indiscriminate cost containment.
- We will resist attempts to ration medical care or to establish a two-tier system of medical care.
- We must inform our patients about the risks of stringent cost containment. Nobody else will.
- We will continue to be the patient's advocate — because it is the American people who stand to lose most if efforts at cost containment are not skillfully, judiciously and sensitively applied. **OSMA**

Ray W. Gifford, Jr., MD, a Cleveland internist, wishes to acknowledge Mr. John Mannix for his help in preparing the article.



What do you know about the Governor's Commission on Health Care Costs? If you don't know anything about it — or even worse — don't think you *want* to know anything about it, please read on. Because, as you will learn . . .

IT'S LATER THAN YOU THINK

By Karen S. Edwards

Like it or not, you can't "just practice medicine" anymore. Well-informed, well-read patients are now asking you to justify your diagnosis — they are not willing to accept your words on face value anymore. High technology is forcing you to make ethical decisions you never had to consider before. And, to top it all off — both government and businesses are taking some good, hard looks at your bill these days — and they're screaming "foul."

Today's physicians no longer have the luxury of wrapping themselves in their busy practice and pretending that all the new developments that have taken place in the health care field the last few years are not affecting them. They can no longer afford — literally or figuratively — to stay out of the political arena with the plea "just leave me alone to practice medicine. That's all I want to do." Because, these days "just practicing medicine" is not enough.

Probably no one knows this better than those in the leadership positions at the Ohio State Medical Association (OSMA).

Traditionally, OSMA leaders, on behalf of the membership, have taken an active role in both state and federal

politics, so that Ohio physicians *could* keep their minds on the practice of medicine.

And that's a tradition that has continued in recent years — perhaps most visibly when Immediate Past President C. Douglass Ford, MD of Toledo cooperated with the new administration on State Medicaid cuts.

But the issues are getting thornier — the parties involved more serious. And maintaining the status quo for physicians is becoming harder and harder to do.

"That's something the average physician out there who just wants to practice medicine needs to hear again and again," says D. Ross Irons, MD, of Bellevue, and Eleventh District Councilor to the OSMA.

It's already a fact with which Dr. Irons is well-acquainted.

As chairman of OSMA's Task Force on Health Care, he knows all too well the political machinations, the intricacies involved in government callings. When he learned last May that Governor Richard Celeste had formed a Commission to study Ohio Health Care Costs, Dr. Irons expanded the scope of his committee to include a study of some of these same concerns.

"We wanted to determine how physicians fit into the state's picture of cost-effective health care, and how best to respond to it," says Dr. Irons.

When given the opportunity to place an OSMA representative on the Commission, President S. Baird Pfahl, Jr., MD, made no hesitation in appointing the Eleventh District Councilor.

Dr. Irons joined six other physicians on the Commission — and at least 40 other individuals, representing a variety of health, government, labor and business groups. The Commission is chaired by J.B. Silvers, a Treuhaft professor of management, and director of Health Systems Management Center at Case Western Reserve University. Joseph Davis, associate director of the Federation for Community Planning, works with the Commission in his capacity as a consultant to the Governor.

The Commission, with Dr. Irons aboard, quickly entered a "Phase I" stage, in which it sought to make recommendations to "put the brake on health care costs" in Ohio.

In an interim report, published in June, last year, the Commission reported:

"It is time for the State of Ohio to actively develop policies and practices leading to more cost effective health care. Our recommendations are designed to be a part of that process."

"The OSMA has always supported the idea of cost-effective health care," says Dr. Irons. "But we are trying to insure that cost-effective care does not risk either access to the health-care system, or the quality of that system. We can not condone measures that would lead to a two-tier system of medical care."

In the report the Commission took a three-pronged approach to their objective.

"For the short term," the report reads, they sought recommendations on "how to achieve immediate budget savings in the state's Medicaid and General Relief-Medical programs."

"For the longer term, how to begin reshaping the health care delivery system so that it can operate in a more cost-effective way."

And, finally, the Commission examined "how to refine the State's long term involvement in health regulation, provision, and financing to benefit the citizens of Ohio."

"The OSMA has always supported the idea of cost-effective health care. But we are trying to insure that cost-effective care does not risk either access to the health-care system, or the quality of that system."

The Commission did come up with a set of recommendations — primarily short-term steps to help reduce costs.

Included in the short-term strategies are the following recommendations:

- Encourage the use of low cost surgical settings through adjustments to current reimbursements.
- Require hospitals to create a multi-tiered outpatient facility fee structure.
- Implement a Diagnostic Related Group (DRG) prospective payment program, based on hospital inpatient services for Medicaid and General-Relief Medical program patients by July 1, 1984.
- Encourage the expansion of HMOs, primary care, and case management systems.
- Begin a pilot project, related to pre-admission screening of nursing home applicants.

But, perhaps more revealing, and somewhat alarming — at least to those physicians who prefer to keep politics out of medicine — is a long-term recommendation that says, "the State should embark upon a new age of experimentation with health delivery systems — experimentation that will facilitate the transition from a situation where there is little control over quality or cost to a new reality where quality of care standards can be monitored and costs can be controlled. Without this longer term view, the short term savings are important, but become piecework. With the longer term in mind, the immediate recommendations set the stage for what is yet to come. They initiate a strategy that will make Ohio a leader in the containment of health care costs."

"The Commission is now in Phase II," says Dr. Irons, "which means we are attempting to fine-tune those recommendations made in Phase I."

The direction the Commission is presently taking with these recommendations, however, indicates that change may be imminent in the way health care is delivered in Ohio.

"As physicians, we feel that, given an adequate fee structure, and some consumer responsibility in paying the costs, the price of health care can be kept down while still maintaining quality," Dr. Irons says. But it's a difficult position to defend, especially with the labor forces.

"Right now, Usual Customary Rates (UCR) are being attacked. There is a

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handling

Cutting down on forms and reducing time-consuming claims handling are important advantages of the new ADVANCE Plan agreement, now being introduced by Ohio Medical Indemnity Mutual Corp., the Blue Shield Plan headquartered in Worthington. The streamlined claims handling procedures designed into the program can reduce your administrative costs – and ours at OMIM as well. The agreement asks that you accept as payment-in-full our UCR reimbursement for covered Basic services you perform. In return, as a cooperating ADVANCE Plan physician, you'll benefit from easier claims procedures, including automatic direct payment to you of Blue Shield Basic claims... reduced CRT terminal costs for use of our OPEN automated, paperless claims data entry system... and a direct toll-free line to an inquiry service in our Worthington offices for questions about procedures and claims. For full details, ask your Blue Shield Professional Relations area representative. Easier claims handling. It's one of the advances of the

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feeling of wanting to move away from the present reimbursement system," Dr. Irons says.

But to what?

"There has been a suggestion to pattern physician fees after the DRG system — to pay physicians by the hour. However, an argument was raised that degree of difficulty should enter into determining costs," says Dr. Irons.

The Commission's one suggestion that stands the greatest possibility of implementation is the idea of creating a data base on health care providers. Under this plan, consumers would be presented with a complete list of providers and what they charge, with the idea that consumers would shop around, compare prices, and make cost-effective decisions in selecting a physician or hospital.

"A data bank for hospital charges will happen in this administration," predicts Eric Burkland, Director of OSMA's Department of State Legislation. But a data bank for physicians would be more difficult to accomplish.

"How would all the data be collected, and how would it be dispensed to the consumer?" is a question Dr. Irons says is still up in the air. But the push to somehow involve consumers in health care costs continue.

"They want to involve the patient in the cost decision, let him or her make the final decision, and enter into direct, contractual relationships with the provider, eliminating the third party," says Dr. Irons.

Businesses and providers, of course, are opting for a capitation system.

"Business wants to be able to hand fifty dollars to a physician every month, and say 'here, take care of our employees' health needs,' " Dr. Irons states.

"But there goes your freedom of choice. If this plan were to be realized, the patient is not going to be able to choose the kind of health care system he or she wants. That choice will be made by whomever is making the payments."

And the choice will be huge.

The alphabet soup of alternative delivery systems is already overflowing — and it's growing everyday. Experts estimate that, by 1990, 50% to 60% of all physicians will be employed in a capitation system, and the fee-for-service, private care delivery system will be destroyed.

"PPOs will be controlled by hospitals and corporations. Of all of them, the IPA has proven to be the most cost-effective, and the most palatable," Dr. Irons says. However, it is the HMOs which are spawning a new concept in care that promises the biggest potential problem.

Experts estimate that, by 1990, fifty to sixty percent of all physicians will be employed in a capitation system, and the fee-for-service, private care delivery system will be destroyed.

"In the large HMOs, all clientele is screened. They are able to pick and choose their Medicaid patients," Dr. Irons says, and, as an aside, notes "where is the guarantee of access to quality care in that? Their answer, however," he continued, "is to turn to a gatekeeper concept, which, in essence, provides one physician — a case manager, if you will, to manage the care of all Medicaid patients in that HMO. That one physician is in charge of prescribing tests — and making all referrals," Dr. Irons says. And therein, lie the problems.

"Beyond the ethics of giving one physician that much clout, we need to discuss the liability involved," Dr. Irons says.

But liability is the physician's strongest argument in any discussion of health care costs.

"We've been forced to practice defensive medicine for years," Dr. Irons says "and that adds substantially to health care costs." For example, in one study, it was shown that 63% of the participating physicians ordered more tests for their patients *because* of defensive medicine," Dr. Irons says, "and those tests ran anywhere from $8 to $450 per patient." Add to that, the results of another study in which 50% to 70% of the physicians interviewed indicated they practice defensive medicine.

It is the fear of litigation that is contributing to higher costs, Dr. Irons attests, indicating that this is one area which deserves further study.

"Several courses of action could be taken. For example, the state could put a ceiling on the malpractice awards granted. Or, they could change the law in tort, shifting responsibility so that the patient would have to prove malpractice, rather than making the physician prove his or her innocence. Either way, reducing the necessity of practicing defensive medicine would result in a cost savings that could be passed onto the patients."

Something needs to be done, though, and soon, he says.

"DRGs are creating a malpractice nightmare — but the only ones who are concerned are the physicians."

And that says a lot. When the total health care picture is viewed, physicians only account for 19% of the costs — less than 6% if you are looking at the state Medicaid dollars spent.

Yet, while it is the physician who is receiving the biggest share of the blame for high health care costs, it is also the physician who is showing, perhaps, the greatest concern.

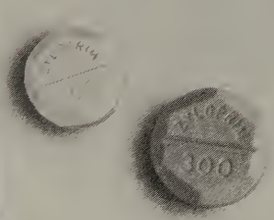
"The doctor has a mission to maintain a heritage of quality care for our patients. When all is said and done, that's the bottom line."

That is why Dr. Irons has devoted so much time and energy to the Commission, and that is why OSMA has become so legislatively active.

"It seems that a hundred different arrows are coming into the private physician all at once . . . from the state, the federal government, businesses and providers. It's mind-boggling. Physicians don't know how to react. They become frantic, or else they walk out, and say 'we don't want to hear about that.' But it's too late for that. The problem is here, and we have to deal with it head-on — or someone will deal with it for us."

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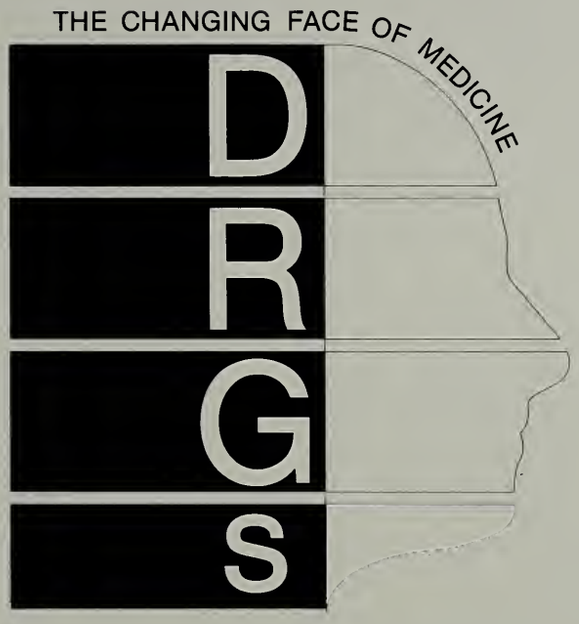
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OSMA 1984 ANNUAL MEETING
MAY 18-23, 1984



The 1984 OSMA Annual Meeting

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Candidate for President-Elect
HERMAN I. ABROMOWITZ, MD



Herman Abromowitz, MD

To many members of the Ohio State Medical Association, Herman I. Abromowitz, MD, is already a familiar face.

This Xenia, Ohio native received his medical degree from Ohio State University in 1958, and, from there, served an internship at Miami Valley Hospital in Dayton. In 1973, he was certified by the American Board of Family Practice, and he was re-certified in 1979. In 1974, he became a Charter Fellow of the American Academy of Family Physicians.

Although Dr. Abromowitz currently has a family practice in Dayton, he is also actively involved with occupational medicine and presently serves as Vice-President of the Western Ohio Occupational Medical Association, and as Delegate to the American Occupational Medical Association. Dr. Abromowitz also manages to find the time for other numerous civic, community and professional activities.

For example, Dr. Abromowitz is a Clinical Professor at Wright State University School of Medicine — both in the Department of Family Practice and Community Medicine. He is on the active staff of Good Samaritan Hospital, where he has served on and chaired a number of committees, and has served as Chief of the hospital's Family Practice Department. A past hospital Board of Trustees member, Dr. Abromowitz currently serves on the Board of Trustees of Samaritan Health Resources, Inc.

His work for the Montgomery County Medical Society has included terms as President (1978) and Trustee, as well as work on various committees — and he serves on the society's Executive Council, Mediation Committee, and Committee on Government and Public Affairs. Dr. Abromowitz is also serving currently as President of the Medical Society Service Bureau.

Dr. Abromowitz has served as a member on the Board of Directors of the Montgomery County Combined Health District for a number of years, and is currently serving a term as President of that Board.

His work for the Ohio State Medical Association (OSMA) has been just as active, and just as impressive.

A past member of numerous committees, some of which include the Federal Legislative Liaison Committee and the Judicial and Professional Relations Committee, Dr. Abromowitz currently serves the OSMA as: Second District Councilor; Chairman of the Auditing and Appropriations Committee; Delegate to the Ohio State Medical Association; Alternate OSMA Delegate to the American Medical Association; and a member of OSMA's Task Force on Health Care.

Dr. Abromowitz has served as Chairman of the Board of Directors of the Physicians Administrative Corporation of Ohio (PACO) since it began two years ago, and has served on the Board of the Professionals Insurance Company since its inception. He is also serving on the Board of Directors of the Ohio Medical Education and Research Foundation.

From 1981-1982, Dr. Abromowitz served as co-chairman of the Ohio Voluntary Effort for the State of Ohio.

Dr. Abromowitz lives in Dayton, with his wife, Joyce; their daughter, Leslie, who is currently a medical student at Wright State University, and their son David who attends Washington and Jefferson College in Washington, Pennsylvania. **OSMA**

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CINCINNATI, OHIO MAY 18-23, 1984

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May 18-23, 1984

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No. of Persons _____ Arrival Date _____ Hour of Arrival _____ Departure Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Reservations for all Convention Groups must be received 21 days prior to arrival.
Rooms will be held until 6:00 P.M. unless payment is guaranteed.
I wish to guarantee this reservation YES ☐ NO ☐

credit card # _____

Type: _____

Please return to:

Reservations Department
Clarion Hotel
141 West Sixth Street
Cincinnati, OH 45202

OSMA 1984 ANNUAL MEETING
MAY 18-23, 1984

ANNUAL MEETING FORMAT

FRIDAY, MAY 18

GENERAL REGISTRATION
8:00 AM
Upper Lobby, Convention Center

OSMA COUNCIL MEETING/BREAKFAST
8:30 AM
Ivory B, The Clarion Hotel

HOSPITAL MEDICAL STAFF SECTION MEETING
10:00-11:30 AM
Bronze A, The Clarion Hotel

OMPAC BOARD LUNCHEON/MEETING
12:00 NOON-2:00 PM
Losantiville, The Clarion Hotel

EMERGENCY RESOLUTIONS COMMITTEE LUNCHEON
12:00 NOON
Ivory A. The Clarion Hotel

OSMA DELEGATION TO AMA MEETING
1:00 PM
Bamboo A & B, The Clarion Hotel

HOUSE OF DELEGATES
3:00-7:00 PM
Registration, Upper Lobby, Convention Center
5:30 PM
Sit-down Dinner, Grand Ballroom B, The Clarion
7:00 PM
Opening Session, Rooms 20, 21, 22, 27 & 28, Convention Center

COUNCILOR DISTRICT CAUCUS
4:00-5:30 PM
Meetings, The Clarion
District 1 — Cabana A & B
District 2 — Ivory B
District 3 — Bamboo B
District 4 — Losantiville
District 5 — Bronze A
District 6 — Bamboo A
District 7 — Suite
District 8 — Suite
District 9 — Suite
District 10 — Ivory A
District 11 — Warren Room
District 12 — Suite
MSS — Suite
(Suites to be announced)

FOLLOWING HOUSE OF DELEGATES
Reception hosted by Academy of Medicine of Cincinnati, Bronze A & B, The Clarion Hotel

SATURDAY, MAY 19

REFERENCE COMMITTEES
7:00 AM
Breakfast, Grand Ballroom B, The Clarion
8:00-11:30 AM
Hearings, Convention Center
Committee No. 1, Room 2
Committee No. 2, Room 3
Committee No. 3 & President's Address, Room 15
Nominations Committee, Room 4
1:30 PM
into Executive Session
(same rooms as earlier)
9:00 PM
Drafts & Reports
Prepared and Reviewed by Committees

GENERAL REGISTRATION
8:00 AM
Upper Lobby, Convention Center

OMPAC
11:30 AM-1:30 PM
Social Hour & Luncheon
Grand Ballroom A & B, The Clarion

PACO COMPUTER DEMONSTRATION
2:00-5:00 PM
Room 23, Convention Center

DISTRICT 5 CAUCUS MEETING
3:00-5:00 PM
Bamboo A & B, The Clarion

MEDICAL MUTUAL & OMIM
4:30-6:00 PM
Combined Reception, Bronze A & B, The Clarion

BECKY THATCHER RIVERBOAT PARTY
7:00-10:00 PM
6:15 PM
Buses leave Clarion Hotel
6:30 PM
Board boat
Buses return to hotel following party

SUNDAY, MAY 20

GENERAL REGISTRATION
8:00 AM
Upper Lobby, Convention Center

COUNCILOR DISTRICT CAUCUS
8:00 AM
Meetings (Reports ready)
District 1 — Cabana A & B, The Clarion
District 2 — Ivory B, The Clarion
District 3 — Bamboo B, The Clarion
District 4 — Losantiville, The Clarion
District 5 — Bronze A, The Clarion
District 6 — Bamboo A, The Clarion
District 7 — Suite, The Clarion
District 8 — Suite, The Clarion
District 9 — Suite, The Clarion
District 10 — Ivory A, The Clarion
District 11 — Warren Room, The Clarion
District 12 — Suite, The Clarion
MSS — Suite, The Clarion
(Suites to be announced)

HOUSE OF DELEGATES
11:30 AM
Registration, Upper Lobby, Convention Center
1:00 PM
Final Session, Rooms 20, 21, 22, 27 & 28 Convention Center
6:00 PM
Sit-down Dinner, Grand Ballroom B, The Clarion
7:00 PM
Resume Final Session (if necessary) — Rooms 20, 21, 22, 27 & 28, Convention Center

MONDAY, MAY 21

GENERAL REGISTRATION
7:30 AM-5:00 PM
Upper Lobby, Convention Center

OHIO COMMITTEE ON TRAUMA, A.C.S. (Advanced Trauma Life Support provider course)
7:30 AM-12:00 NOON
Meeting, Room 15, Convention Center
12:00 NOON-1:00 PM
Luncheon, Ivory B, The Clarion
1:00 PM
Bus departs to University of Cincinnati

OSMA COUNCIL MEETING/BREAKFAST
8:30 AM
Ivory B, The Clarion

SPORTS MEDICINE
8:30 AM-12:00 NOON
Meeting, Room 3, Convention Center
12:00 NOON-1:00 PM
Luncheon, Bronze A, The Clarion
1:00-4:00 PM
Meeting Resumes, Room 3, Convention Center

OPHTHALMOLOGY
8:30 AM-4:00 PM
Meeting, Room 2, Convention Center
4:00-6:00 PM
Business Meeting, Room 2, Convention Center

NEUROLOGY
8:00 AM-12:00 NOON
Meeting, Room 14, Convention Center
12:00 NOON
Luncheon, Bamboo A, The Clarion

OTOLARYNGOLOGY
9:00 AM-4:00 PM
Meeting, Room 20, Convention Center
12:00 NOON
Luncheon, Bronze B, The Clarion

OHIO SOCIETY OF INTERNAL MEDICINE
9:00 AM-12:00 NOON
Meeting, Room 1, Convention Center

continued on page 279

Just once each day...

First-step blood pressure control with optimal simplicity

Benefits diuretics cannot offer . . . Once-daily INDERAL LA (propranolol HCl) provides smooth, 24-hour control of blood pressure plus the cardiovascular benefits of the world's leading beta blocker. And INDERAL LA provides a high degree of patient acceptance—without potassium problems.

Experience no other beta blocker can match . . . Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories

Just once each day for initial therapy in hypertension.

Ayerst

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement for any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end-systolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine- or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in cerebral vessels, and it is thought that the

Beta receptor blockade can be useful in conditions in which because of pathophysiologic functional changes, sympathetic activity is detrimental. There are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing dose levels up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity or carcinogenic effects at any of the dosage levels used. Reproduction studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses approximately 3 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Adverse effects have been mild and transient and have rarely required withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; claudication; cold extremities; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8950/284

Just once each day.

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

PICO
10:00 AM
Shareholders Meeting, Room 13, Convention Center
RHEUMATOLOGY
12:00 NOON-1:30 PM
Luncheon/Business Meeting, Losantiville, Clarion
1:30-5:00 PM
Meeting, Room 4, Convention Center
RADIOLOGY
1:00-4:00 PM
Meeting, Room 21, Convention Center
PATHOLOGY
4:30-7:00 PM
Board of Governors Meeting, Room 5, Convention Center
NEUROSURGERY
4:00-6:30 PM
Business Meeting, Room 8, Convention Center
7:00 PM
Cocktails/Dinner, Queen City Club

TUESDAY, MAY 22

GENERAL REGISTRATION
7:30 AM-5:00 PM
Upper Lobby, Convention Center
NEUROSURGERY
7:30-8:30 AM
Breakfast, Ivory B, The Clarion
8:30 AM-12:10 PM
Meeting, Room 20, Convention Center
12:30-1:30 PM
Luncheon, Ivory B, The Clarion
1:30 PM
Resume Meeting, Room 20, Convention Center
OHIO COMMITTEE ON TRAUMA, A.C.S.
8:00 AM-12:00 NOON
Meeting, Room 25, Convention Center
12:00 NOON
Luncheon, Commodore Room, The Clarion
1:00-4:00 PM
Rooms 22 & 25
OPHTHALMOLOGY
8:30 AM-12:00 NOON
Scientific Meeting, Room 2, Convention Center
PATHOLOGY
9:00 AM-12:30 PM
Meeting, Room 21, Convention Center
12:30-1:30 PM
Luncheon, Bronze B, The Clarion
1:30-5:00 PM
Resume Meeting, Room 21, Convention Center
DERMATOLOGY
1:00-5:00 PM
Program, Room 1, Convention Center
FAMILY MEDICINE
1:00-5:00 PM
Meeting, Room 3, Convention Center
OHIO PSYCHIATRIC ASSOCIATION
5:00-11:00 PM
Council Meeting, Room 14, Convention Center
6:00-7:00 PM
Council Dinner, Bamboo A, The Clarion

WEDNESDAY, MAY 23

GENERAL REGISTRATION
7:30 AM
Upper Lobby, Convention Center
OHIO PSYCHIATRIC ASSOCIATION
8:30 AM-12:30 PM
Scientific Program, Room 3, Convention Center
12:30-3:00 PM
Luncheon, Bronze B, The Clarion (followed by business meeting)
ALLERGY AND IMMUNOLOGY
8:00 AM-12:00 NOON
Meeting, Room 20, Convention Center
Luncheon (outside of hotel)
PLASTIC SURGERY
9:00 AM-12:30 PM
Meeting, Room 13, Convention Center
PHYSICAL MEDICINE AND REHABILITATION
12:00 NOON-1:30 PM
Luncheon, Bronze A, The Clarion
1:30-4:00 PM
Meeting, Room 1, Convention Center
5:00 PM
Cocktails/Dinner, Bronze A, The Clarion
COLON AND RECTAL
12:00 NOON
Luncheon, Bamboo B, The Clarion
UROLOGICAL SOCIETY
12:00 NOON-1:00 PM
Luncheon, Ivory B, The Clarion
1:00-3:00 PM
Meeting, Room 5, Convention Center
INTERPROFESSIONAL EDUCATION & PRACTICE
1:00-4:00 PM
Meeting, Room 21, Convention Center. **OSMA**

It's Later Than You Think

continued from page 269

"The physician who keeps his or her head in the sand may not be around much longer. It's that simple, and that grim. Sure, the problems have been around awhile — but they haven't gone away. They've gotten worse, more intense. People are becoming more serious about solving them. That is why organized medicine is so important right now. We have to stick together and see this through. As organized medicine, we're not in it alone, but if we want to maintain the integrity of medical care for our patients, we are going to have to do something about health care costs. We have to think about it, and act when it is appropriate to act. We can't ignore the issues anymore and hope they will go away. We have to make ourselves aware of the problems *now*. Tomorrow may be too late." **OSMA**

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OSMA 1984 ANNUAL MEETING
MAY 18-23, 1984

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Charles E. Smith
James C. Taddeo
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Warren W. Smith
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Seventh District.....H. Judson Reamy
Eighth District.....Carl E. Spragg
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Tenth District .....D. James Hickson
Eleventh District.....D. Ross Irons
Twelfth District .....Joseph L. Kloss
Medical Student Section ....Alan T. Mong

Art and Culture Committee Schedules Art Exhibit

What better time than during Annual Meeting to take a look at society's attitude toward food and drink? This year as part of its annual exhibit, the OSMA's Art and Culture Committee will sponsor an exhibit entitled, "Consuming Passions: The Art of Food and Drink." The exhibit, which is a condensed version of one which appeared at the Cleveland Museum of Art, reflects how artists through the centuries have portrayed food and its impact on all aspects of our lives.

The exhibit was coordinated by Ralph Fried, M.D., a member of the Art and Culture Committee.

Please don't leave Cincinnati this year without stopping by the Art and Culture exhibit. It will be in the lobby of the Convention Center.

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OSMA 1984 ANNUAL MEETING
MAY 18-23, 1984

Delegates and Alternates Schedule

FRIDAY, MAY 18

3:00-7:00 PM
Registration for OSMA House of Delegates
Upper Lobby, Convention Center

4:00 PM
Councilor District Caucus Meetings
Caucus Suites will be posted at the Registration Desk

5:30 PM
Dinner for Delegates, Alternates, OSMA Council and Official Guests
Grand Ballroom B, Clarion Hotel

7:00 PM
Opening Session, OSMA House of Delegates
Rooms 20, 21, 22, 27 & 28, Convention Center

BUSINESS AGENDA OPENING SESSION

Call to Order
S. Baird Pfahl, Jr., M.D., Huron
President

Invocation

Welcome
William H. Gates, M.D., Cincinnati
President, Academy of Medicine of Cincinnati

Report
Committee on Credentials

Consideration of Minutes of 1983 Annual Meeting
(See July 1983 issue of The Ohio State Medical Journal)

Introduction of Members, AMA Board of Trustees

Introduction of Honored Guests

Report
Mrs. Stella Brown, Dayton
OSMA Auxiliary President

Distinguished Service Citations (awarded posthumously)
Perry R. Ayres, M.D.
Milton M. Parker, M.D.

AMA-ERF Presentations
Philip B. Hardymon, M.D., Columbus
Chairman, Ohio Committee on AMA-ERF

Presentation of Plaques
To past Councilors, retiring AMA Delegates and Alternates and Chairmen of Committees

Announcement
S. Baird Pfahl, Jr., M.D., Huron
Appointments to Resolutions Committees, Credentials, and Tellers and Judges of Election Committees.

Election of Committee on Nominations
Nominations from the floor. One representative (delegate) from each Councilor District. The committee shall report to the second and final session, Sunday, May 20, 1:00 p.m., its recommendations in the form of a ticket containing nominees for offices to be filled at this meeting as required under the Constitution and Bylaws. Under the rotation plan established in 1963, the committeeman from the Eleventh District shall serve as Chairman. The report of the Nominating Committee with respect to all offices except President-Elect shall be posted at the registration desk, earliest time practicable and at least three hours before the final session of the House of Delegates.

President's Address
S. Baird Pfahl, Jr., M.D., Huron

Introduction of Presidents of Other State Societies

Introduction of Representatives of Allied Organizations

Introduction of Resolutions
Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Sunday afternoon session before any action can be taken.

Miscellaneous Business

SATURDAY, MAY 19

7:00-8:00 AM
Buffet breakfast for Delegates, Alternates, OSMA Council and Official Guests
Grand Ballroom B, Clarion Hotel

8:00-11:30 AM
Reference Committee Hearings, Convention Center
Res. Committee No. 1 — Room 2
Res. Committee No. 2 — Room 3
Res. Committee No. 3 & President's Address — Room 15
Nominating Committee — Room 4

3:00-5:00 PM
District 5 Caucus Meeting, Bamboo A & B, Clarion Hotel

SUNDAY, MAY 20

8:00 AM
Councilor District Caucus Meetings
Caucus locations will be posted at the Registration Desk

11:30 AM-1:00 PM
Registration for OSMA House of Delegates
Upper Lobby, Convention Center

1:00 PM
Final Session, OSMA House of Delegates
Rooms 20, 21, 27 & 28, Convention Center

6:00 PM
Dinner for Delegates, Alternates, OSMA Council and Official Guests
Grand Ballroom B, Clarion Hotel

7:00 PM
Continuation of Final Session (if necessary)

ORDER OF BUSINESS FINAL SESSION

Introduction of Guests

Report of Committee on Credentials

Election of President-Elect

Report of Committee on Nominations and Election of Other Officers

Election of Members of The Council
Members of The Council are elected for two-year terms; terms of those representing the odd-numbered districts expire in even-numbered years. First District: Incumbent, John E. Albers, M.D., Cincinnati; Third District: Incumbent, Thomas R. Leech, M.D., Lima; Fifth District: Incumbent, Donavin A. Baumgartner, Jr., M.D., Cleveland; Seventh District: Incumbent, H. Judson Reamy, M.D., New Philadelphia (not eligible for re-election having served his three two-year terms); Ninth District: Incumbent, Thomas P. Price, Jr., M.D., Gallipolis; Eleventh District: Incumbent, D. Ross Irons, M.D., Bellevue.

Election of Delegates and Alternates to the AMA
Seven Delegates and seven Alternates to be elected for a two-year term starting January 1, 1985, in compliance with the Constitution and Bylaws of the American Medical Association. The following incumbent Delegates and Alternates will serve for the remainder of 1984, their terms expiring December 31, 1984.
Delegates (listed alphabetically):
Theodore J. Castele, M.D., Cleveland; Stewart B. Dunsker, M.D., Cincinnati; Jerry L. Hammon, M.D., Dayton; H. William Porterfield, M.D., Columbus; Jack Schreiber, M.D., Canfield; Robert N. Smith, M.D., Toledo; and Robert G. Thomas, M.D., Elyria.
Alternates (listed alphabetically):
A. Robert Davies, M.D., Troy; Roland A. Gandy, Jr., M.D., Toledo; Ray W. Gifford, Jr., M.D., Cleveland; Edward G. Kilroy, M.D., Cleveland; Carl E. Spragg, M.D., New Concord; Joseph Sudimack, Jr., M.D., Warren; and Claire V. Wolfe, M.D., Dublin.
All nominees for the offices of AMA Delegates and Alternate Delegates shall run at large. Election of Delegates and Alternate Delegates of the AMA shall be

continued on page 293

OSMA 1984 ANNUAL MEETING
MAY 18-23, 1984

Continuing Medical Education Courses

ALLERGY AND IMMUNOLOGY

CME Hours: 3½ Category I
Date: Wednesday, May 23
Place: Room 20, Convention Center
Time: 8:00 AM-12:00 Noon
Sponsor: OSMA Section on Allergy and Ohio Society of Allergy and Immunology

8:00-8:10 AM
Introduction
— Ann C. Ghory, M.D., Program Chairman, Cincinnati

8:10-9:00 AM
"Atopic Dermatitis"
— Stephen Estes, M.D., Director of Dermatology, University Hospital, Cincinnati

9:05-9:50 AM
"Recurrent Sinusitis Update"
— Jack Gluckman, M.D., Director of Otolaryngology, Holmes Hospital, Cincinnati

9:55-10:15 AM
Coffee Break

10:15-11:00 AM
"Managing the Pregnant Asthmatic"
— Paul Greenberger, M.D., Associate Professor, Division of Allergy-Immunology, Northwestern University, Chicago, Illinois

11:10-12:00 PM
"Managing the Asthmatic Child"
— Douglas Johnstone, M.D., Division of Allergy-Immunology, Rochester, New York

12 Noon
Reception/Luncheon/Business Meeting
RSVP Restaurant

COMMISSION ON INTERPROFESSIONAL EDUCATION AND PRACTICE

CME Hours: 3 Category I
Date: Wednesday, May 23
Place: Room 21, Convention Center
Time: 1:00 to 4:00 PM
Sponsor: Commission on Interprofessional Education and Practice, The Ohio State University
Topic: The Interprofessional Team in Action
Schedule:

1:00-1:20 PM
Welcome and Background Information
— Donald J. Vincent, M.D., Director of Gerontology, Riverside United Methodist Hospital, Columbus

1:20-1:40 PM
Videotape: "Please Let Me Die"

1:40-2:05 PM
Medical Dimensions of the Case
— Donald J. Vincent, M.D., (Internist)
— Jeffery C. Hutzler, M.D., Assistant Professor, Psychiatry, College of Medicine, Ohio State University

2:05-2:15 PM
Legal Issues
— James E. Pohlman, (Lawyer), Porter, Wright, Morris and Arthur, Columbus

2:15-2:25 PM
Nursing Issues
— Mary Beth Strauss, R.N., Ph.D., (Nurse), Director of Continuing Education, College of Nursing, Ohio State University

2:25-2:35 PM
Theological Issues
— Edwin R. Kopp, M. Div., (Hospital Chaplin), Director of Pastoral Care, Children's Hospital, Columbus

2:35-2:55 PM
Summary and Recommendations of the Interprofessional Team

2:55-3:25 PM
Discussion

3:25-3:30 PM
Outcome of the Case
— Donald J. Vincent, M.D.

3:30-4:00 PM
Coffee — Commission Slide/Tape

4:00 PM
Adjournment

DERMATOLOGY

CME Hours: 4 Category I
Date: Tuesday, May 22
Place: Room 1, Convention Center
Time: 1:00 to 5:00 PM
Sponsor: OSMA Section on Dermatology and Ohio Dermatological Association

1:00-1:10 PM
Introduction
— Charles L. Heaton, M.D., Associate Professor of Dermatology, University of Cincinnati College of Medicine

1:15-2:00 PM
"Common Dermatoses: Their Diagnosis and Treatment"
— K. William Kitzmiller, M.D., F.A.C.P., Associate Clinical Professor of Dermatology and Assistant Clinical Professor of Family Medicine, University of Cincinnati College of Medicine

2:00-2:15 PM
Questions and Answers

2:15-3:00 PM
"A Potpourri of Pigmented Problems — Their Diagnosis and Treatment"
— James J. Nordlund, M.D., Professor of Dermatology; Director, Department of Dermatology, University of Cincinnati College of Medicine

3:00-3:15 PM
Questions and Answers

3:15-4:00 PM
"Psoriatic Arthritis: Its Diagnosis and Treatment"
— Paul A. Lucky, M.D., Associate Professor of Dermatology, University of Cincinnati College of Medicine

4:00-4:15 PM
Questions and Answers

4:15-4:45 PM
"Is Accutane Really a Miracle Drug For Acne?"
— Z. Charles Fixler, M.D., Associate Clinical Professor of Dermatology, University of Cincinnati College of Medicine

4:45-5:00 PM
Questions and Answers

INTERNAL MEDICINE

CME Hours: 3 Category I
Date: Monday, May 21
Place: Room 1, Cincinnati Convention Center
Time: 9:00 A.M.-12:00 Noon
Sponsor: OSMA Section on Internal Medicine and The Ohio Society of Internal Medicine
Moderator:
Lee McHenry, M.D.
Immediate Past President
Ohio Society of Internal Medicine
Cincinnati
Program & Faculty:
"A Fork in the Road of Medical Care — The Two Faces of Medicine"
(The following panel participants will be discussing the pressures toward a two-tiered medical system. All are welcome.)

Ms. Bonnie Brown
Legislative Aide to Congressman Willis D. Gradison
Washington, D.C.

Mr. William M. Copeland
President and Chief Executive Officer
St. Francis-St. George Hospital and Health Services
Cincinnati

William J. Marshall, M.D.
ACP/OSIM Delegate to the Ohio State Medical Association
Dayton

Mr. Richard A. Thompson
Vice President
Consumer Medical Cost Containment Corporation
Cincinnati

Mr. Thomas C. Nelson
Coordinator, Consumer Affairs
American Association of Retired Persons
National Headquarters
Washington, D.C. 20049

A representative to be named from industry

NEUROLOGY

CME Hours: 5 Category I
Date: Monday, May 21
Place: Room 14, Convention Center
Time: 8:00 AM-1:00 PM
Sponsor: OSMA Section on Neurology
Schedule:
8:00-8:45 AM
Intractable Epilepsy: Patient Selection for Surgical Therapy
— Patricia E. Penovich, M.D., Cincinnati
8:45-9:35 AM
Spinal Cord Injury: A Clinical and Experimental Update
— Eugene D. Means, M.D., Cincinnati
— Douglas K. Anderson, Ph.D., Cincinnati
9:35-9:45 AM
Coffee
9:45-10:35 AM
Delirious Effects of Elevated Serum Glucose Concentration In Cerebral Ischemia (stroke)
— Ronald E. Myers, Ph.D., M.D., Cincinnati
10:35-11:30 AM
Cerebral Embolism of Cardiac Origin
— Thomas G. Brott, M.D., Cincinnati
11:45-1:00 PM
Presentation of short original research papers
1:00 PM
Luncheon — Bamboo A, Clarion Hotel

NEUROSURGERY

CME Hours: 3½ Category I
Date: Monday, May 21 and Tuesday, May 22
Places: Queen City Club, Cincinnati Convention Center and Clarion Hotel
Sponsor: Ohio State Neurological Society & OSMA Section on Neurosurgery
Moderators: John R. Little, M.D. Cleveland; James C. Barnes, M.D. Columbus
Schedule:
Monday, May 21
4:00-6:00 PM
Business Meeting, Room 8, Cincinnati Convention Center
7:00 PM
Cocktails and Dinner, Queen City Club, 331 E. 4th Street
Tuesday, May 22
7:30-8:30 AM
Neurosurgery Breakfast, Ivory B, Clarion Hotel
8:30-12:10 PM
Scientific Program
Room 20, Convention Center
8:30-9:20 AM
A Piece of Mind — Frank Mayfield, M.D., Cincinnati
9:20-10:10 AM
Application of NMR to the Diagnosis and Treatment of Neurosurgical Disorders
— Michael Modic, M.D., Cleveland
10:10-10:30 AM
Coffee Break
10:30-11:20 AM
Positron Emission Tomography and Cerebral Tumor Metabolism. Edward Ganz, MD, Case Western Reserve University, Cleveland
11:20-12:30 PM
Neurosurgical Experiences in Neuro-otology
— Horace Norrell, M.D., Sarasota Florida
12:30-1:30 PM
Luncheon — Room Ivory B, Clarion Hotel
1:30-2:30 PM
Luncheon Speaker
What Now? What Next?
— Steve Loebs, Ph.D., Columbus

OPHTHALMOLOGY

CME Hours: 9 Category I
Date: Monday, May 21 and Tuesday, May 22
Place: Room 2, Cincinnati Convention Center
Time: Monday, 8:30 AM-6:00 PM, Tuesday, 8:30 AM-12:30 PM
Sponsor: OSMA Section on Ophthalmology and the Ohio Ophthalmological Society
Monday, May 21
8:30-8:40 AM
Welcome
8:40-9:10 AM
Tarsorrhaphy: Indications & Method
— Dwight R. Kulwin, M.D., Cincinnati
9:10-9:40 AM
How to Select and Use Surgical Instruments
— Kevin T. Fitzgerald, Storz Instrument Company, Cincinnati
9:40-9:55 AM
How to Select and Use Needles
— Tom Campbell, Davis & Geck, Cincinnati
9:55-10:10 AM
How to Select and Use Sutures
— Lance Rogers, Ethicon, Inc., West Chester
10:10-10:20 AM
Questions and Answers
10:20-10:35 AM
Coffee Break
10:35-11:05 AM
Management of Pediatric Epiphora
— John Burns, M.D., Columbus
11:05-11:30 AM
Radiologic Evaluation of Orbital Trauma
— James Moses, M.D., Columbus
11:30-11:55 AM
Lid Margin Surgery and Canthotomy
— Robert O'Dair, M.D., Columbus
11:55-12 Noon
Questions and Answers
12 Noon-1:30 PM
Luncheon
1:30-2:00 PM
Practical Eyelid Anatomy
— Richard Dortzbach, M.D., Madison, Wisconsin
2:00-2:30 PM
Ectropion
A. Jan Berlin, M.D., Cleveland
2:30-3:00 PM
Entropion
— Donald Jansen, M.D., Cincinnati
3:00-3:15 PM
Break
3:15-3:45 PM
New Developments in Facial Surgery
— Henry Neale, M.D., Cincinnati
3:45-4:00 PM
Questions and Answers
4:00-6:00 PM
Business Meeting and Cocktails
Tuesday, May 22
8:30-9:00 AM
Functional Blepharoplasty
— Richard Dortzbach, M.D.
9:00-9:30 AM
Wound Closure
— Rodney McCarthy, M.D., Toledo
9:30-10:00 AM
Orbital Manifestations of Sinus Disease
— J. Oliver Donegan, M.D., Cincinnati
10:00-10:10 AM
Questions and Answers
10:10-10:25 AM
Coffee Break
10:25-10:55 AM
Enucleation
— William Nunnery, M.D., Indianapolis, Indiana
10:55-11:25 AM
Cancer Excision and Frozen Sections
— Abbot Spaulding, M.D., Cincinnati
11:25-11:50 AM
Preop and Postop Care
Rodney McCarthy, M.D.
11:50-12:15 PM
What to Expect of an Ocularist
Kathy Hetzler, Ocularist, Indianapolis, Indiana
12:15-12:30 PM
Questions and Answers
12:30
Adjourn

OTOLARYNGOLOGY

CME Hours: 5 Category I
Date: Monday, May 21
Place: Room 20, Convention Center
Time: 9:00 AM-4:00 PM
Sponsor: OSMA Section on Otolaryngology and Ohio Society of Otolaryngology
Presiding Officer: Jack L. Gluckman, M.D., Program Chairman, Cincinnati
Topic: Current Concepts in Modern Rhinology
9-9:05 AM
Introduction
— Jack L. Gluckman, M.D., President and Program Chairman, Cincinnati
9:05-9:45 AM
Post Rhinoplasty Nasal Obstruction
— Howard Levine, The Cleveland Clinic Foundation, Cleveland
9:45-10:30 AM
Advances in the Diagnosis and Management of Allergic Rhinitis (Part 1)
— Donald Nalebuff, M.D., Teaneck, New Jersey
10:30-10:45 AM
Coffee
10:45-11:30 AM
Advances in the Diagnosis and Management of Allergic Rhinitis (Part II)
— Donald Nalebuff, M.D.
11:30 AM-12 NOON
Hypophysectomy — The ENT Surgeons Role
— Bruce Pearson, M.D., Mayo Clinic/ENT Department, Rochester,

Minnesota
12 NOON-1:30 PM
Lunch — Business Meeting
Bronze B, The Clarion Hotel
1:30-2:15 PM
Practical Approach to the Management of CSF Rhinorrhea
— Bruce Pearson, M.D.
2:15-2:45 PM
Anosmia — A Diagnostic Dilemma
— J. Oliver Donegan, M.D., University of Cincinnati Medical Center, Cincinnati
2:45-3:30 PM
Pterygo-Palatine Fossa Surgery
— Bruce Pearson, M.D.
3:30-4:00 PM
Panel

PATHOLOGY

CME Hours: 6 Category I
Date: Tuesday, May 22
Place: Cincinnati Convention Center, Room 21
Time: 9:00 AM-5:00 PM
Sponsor: OSMA Section on Pathology and the Ohio Society of Pathologists
Topic: *Newer Diagnostic Techniques in Pediatric Pathology*
Schedule:
9:00-9:15 AM
Introduction
— Shan Mohammed, M.D., President, Ohio Society of Pathologists, Norwalk
9:15-9:45 AM
Common Origin of Carotid Artery
— Benjamin H. Landing, M.D., Chairman, Department of Pathology, Los Angeles Children's Hospital
9:45-10:15 AM
Pre-T-cell Leukemia
— Gerald Penn, M.D., Columbus
10:15-10:30 AM
Coffee Break
10:30-11:00 AM
Hemolytic-uremic Syndrome
— Robert Novak, M.D., Silver Lake
11:00-11:30 AM
Alpha-1 Antitrypsin Deficiency
— James Patrick, M.D., Maumee
11:30-12:30 PM
Business Meeting
12:30-2:00 PM
Luncheon — Room Bronze B, Clarion Hotel
2:00-2:30 PM
Rhabdomyosarcoma
— William Newton, M.D., Columbus
2:30-3:00 PM
Nesidioblastosis
— Cynthia Daugherty, M.D., Cincinnati
3:00-3:15 PM
Coffee Break
3:15-3:45 PM
Leigh's Disease
— Carl Boesel, M.D., Dayton
3:45-4:15 PM
Pulmonary Alveolar Septal Calcinosis
— Benjamin H. Landing, M.D.
4:15-4:45 PM
Panel Discussion
4:45-5:00 PM
Announcements
— Shan Mohammed, M.D.
5:00 PM
Adjournment

PHYSICAL MEDICINE & REHABILITATION

CME Hours: 3½ Category 1
Date: Wednesday, May 23
Place: Room 1, Cincinnati Convention Center
Time: 1:30 PM
Sponsor: Ohio Society of Physical Medicine and Rehabilitation and the OSMA Section on Physical Medicine and Rehabilitation
Schedule:
12 Noon-1:30 PM
Luncheon and Business Meeting, Bronze A Room, Clarion Hotel
1:30-2:00 PM
Introduction to Computers in Medicine
— Randall L. Braddom, M.D., Cincinnati
2:00-3:00 PM
Current Theoretical Approaches to Cognitive Retraining in Head Injury
— Odie Bracy, Ph.D., Indianapolis, Indiana
3:00-4:00 PM
Computerized Cognitive Retraining (Lecture and Demonstration
— Odie Bracy, Ph.D.
5:00-5:30 PM
Cocktails (cash bar)
5:30 PM
Dinner
Bronze A Room, The Clarion Hotel

PLASTIC SURGERY

CME Hours: 3 Category I
Date: Wednesday, May 23
Place: Room 13, Cincinnati Convention Center
Time: 9:00 AM to 12:30 PM
Sponsor: OSMA Section on Plastic Surgery
Schedule:
9:00-9:15 AM
Introduction
— Robert G. Slagle, M.D., Cincinnati
9:15-9:50 AM
Post-Mastectomy Reconstruction: An Update
— Henry W. Neale, M.D., Cincinnati
9:50-10:25 AM
Microvascular Transfer of Undescended Testes
— Mark Handler, M.D., Cincinnati
— Jeffrey Wacksman, M.D., Cincinnati
10:25-10:40 AM
Coffee Break
10:40-11:10 AM
The Use of Tissue Expanders in Reconstructive Surgery
— Chedomir Radovan, M.D., Encino, California
11:10-11:35 AM
The Use of Forearm Muscle Flaps for Coverage of Chronically Exposed Dialysis Access Grafts
— Michael G. Leadbetter, M.D., Cincinnati
11:35-12:10 PM
Maxillofacial Prosthedontics in Reconstructive Surgery
— Gordon Huntress, D.D.S., Columbus
12:10-12:30 PM
Questions and Answers

PSYCHIATRY

CME Hours: 3½ Category I
Date: Wednesday, May 23
Place: Room 3, Cincinnati Convention Center
Time: 8:30 AM-12:30 PM
Sponsor: Ohio Psychiatric Association
Topic: *Physicians and Violence: What Can We Do?*
Schedule:
8:30-8:45 AM
Luis F. Ramirez, M.D., Moderator
Assistant Professor of Psychiatry, Case Western Reserve University School of Medicine, Cleveland
8:45-10:00 AM
Phillip J. Resnick, M.D.
Associate Professor of Psychiatry; Director of Division of Forensic Psychiatry, Case Western Reserve University School of Medicine, Cleveland
10:00-10:15 AM
Question and Answer Period
10:15-10:30 AM
Coffee Break
10:30-11:45 AM
Kathleen Quinn, M.D.
Assistant Professor of Psychiatry, Department of Psychiatry, Case Western Reserve University School of Medicine, Cleveland
11:45-12:15 PM
Question and Answer Period
12:30 PM
Luncheon — Room Bronze B, Clarion Hotel
Followed by Business Meeting

RADIOLOGY

CME Hours: 3 Category I
Date: Monday, May 21
Place: Room 21, Convention Center
Time: 1:00-4:00 PM
Sponsor: OSMA Section on Radiology & the Ohio State Radiological Society
Faculty: All speakers are members of the Department of Radiology, University Hospital, Cincinnati
Presiding Officer: Robert A. Clark, M.D., Associate Professor of Radiology, University Hospital, Cincinnati
Schedule:
1:00-1:45 PM
An Update on Breast Imaging — Myron Moskowitz, M.D.
Professor of Radiology
1:45-2:30 PM
Computed Tomography of the Spine and Intervertebrae Disk — Thomas Tomsick, M.D., Associate Professor of Radiology
2:30-3:15
The Current Status of Coronary Angioplasty and Thrombolysis — Thomas E. Gallant, M.D., Assistant Professor of Radiology
3:15-4:00 PM
An Update on Digital Vascular Imaging — James Ball, M.D., Assistant Professor of Radiology

RHEUMATOLOGY

CME Hours: 3 Category I
Date: Monday, May 21
Place: Room 4, Convention Center and

Losantiville Room, Clarion Hotel
Time: 12 Noon to 5:00 PM
Sponsor: Ohio Rheumatism Society and OSMA Section on Rheumatology
Course Director: Bruce A. Wall, M.D., Clinical Assistant Professor, Ohio State University College of Medicine
Schedule:
12 Noon-1:30 PM
Luncheon Meeting — Losantiville Room, Clarion Hotel
1:30-2:20 PM
Controversies in Cutaneous Rheumatology
— Jeffrey P. Callen, M.D., F.A.C.P., Associate Professor of Medicine, University of Louisville, Louisville, Kentucky
2:20-3:00 PM
Current State of the Art in Surgery for Arthritis of the Upper Extremities
— Clark Hopson, M.D., Chairman of the Department of Orthopedic Surgery, University of Cincinnati
3:00-3:30 PM
Coffee Break
3:30-4:20 PM
A General Overview of the Seronegative Spondyloarthropathies
— Gary M. Kammer, M.D., Assistant Professor of Medicine. Division of Rheumatic Diseases, Case Western Reserve University, Cleveland
4:20-5:00 PM
Oral Gold (Aufanofin) and the Treatment of Rheumatoid Arthritis
— Robert I. Finkel, M.D., Chief, Rheumatology Subsection, Toledo Hospital; Clinical Assistant Professor of Medicine, Medical College of Ohio, Toledo

SPORTS MEDICINE

CME Hours: 7 Category I
Date: Monday, May 21
Place: Room 3, Cincinnati Convention Center and Clarion Hotel
Time: 9:00 AM to 5:30 PM
Sponsor: OSMA Section on Sports Medicine
Schedule:
9:00-9:10 AM
Introduction
— Frank R. Noyes, M.D., Director, Cincinnati Sportsmedicine and Orthopaedic Center, Cincinnati
Robert S. Heidt, Jr., M.D., Director, Wellington Sports Medicine Center, Cincinnati
9:10-9:20 AM
Speaker: (To Be Announced)
9:20-9:40 AM
Diagnosis And Treatment of General Sports Injuries
— Robert S. Heidt, Jr., M.D.
9:40-10:00 AM
Rehabilitation of General Sports Injuries
— Paul Sparling, L.P.T., A.T., C., Assistant Trainer, Cincinnati Bengals
10:00-10:20 AM
Physical Examination of the Knee — Patient Examination
Frank R. Noyes, M.D.,
10:20-10:40 AM
Rehabilitation of the Knee
— Robert E. Mangine, L/P.T., A.T., C., M.Ed., Administrative Director, Rehabilitation Division, Cincinnati Sportsmedicine and Orthopaedic Center
10:40-10:50 AM
Coffee Break
10:50-11:10 AM
The Role of Arthroscopy in Sports Medicine
— Frank R. Noyes, M.D.
11:10-11:30 AM
Ankle Injuries — Prevention, Diagnosis and Treatment
— Mark G. Siegel, M.D., Clinical Instructor, Department of Orthopaedic Surgery, University of Cincinnati Medical Center; Codirector, Cincinnati Sportsmedicine and Orthopaedic Center
11:30-11:50 AM
Rehabilitation of Ankle Injuries
— Tim Heckmann, L.P.T., A.T., C., Director, Rehabilitation Services, Cincinnati Sportsmedicine and Orthopaedic Center
12 Noon-1:00 PM
Lunch
1:00-1:20 PM
Overuse Syndromes and Shoulder Injuries
— Warren G. Harding, M.D., Clinical Instructor, Department of Orthopaedic Surgery, University of Cincinnati Medical Center
1:20-1:40 PM
Pediatric Sports-Related Injuries
— S. Michael Lawhon, M.D., Clinical Instructor, Department of Orthopaedic Surgery, University of Cincinnati Medical Center
1:40-2:00 PM
Head and Neck Injuries: Recognition and Treatment
— Frank Manarino, M.D., Director, St. Elizabeth Medical Center Sports Clinic, Dayton
2:00-2:20 PM
Heat Stroke/Heat Exhaustion
— Frank W. Cianciolo, M.D., Medical Director, Cincinnati Bell; Team Physician, Moeller High School, Cincinnati
2:20-2:40 PM
Drugs and The Athlete
— Michael Gray, Ph.D., Associate Professor and Director, Human Performance Laboratory, Northern Kentucky University, Highland Heights, Kentucky
2:40-3:00 PM
Nutritional Concerns of the Athlete
— Diane Schneider, Registered Dietician, Cincinnati
3:00-3:10 PM
Coffee Break
3:10-3:30 PM
Legal Aspects of Sports Medicine
— John G. Cobey, Esq., Partner, Cohen, Todd, Kite and Stanfold, Cincinnati
3:30-3:45 PM
Dental Injuries
— Mark J. Fleming, D.D.S., Cincinnati
3:45-4:00 PM
Dermatological Problems of the Athlete
— George Haney, M.D., Cincinnati
4:00-4:15 PM
Problems of the Female Athlete
— Janet Shepherd, M.D., Cincinnati
4:15-4:30 PM
Eye Injuries
— Andrew Robbins, M.D., Chairman, Ophthalmology Section, Good Samaritan Hospital, Cincinnati
4:30-5:30 PM
Workshop Session: Demonstration of Special Taping and Padding Techniques
— Robert E. Mangine, L.P.T., A.T., C.
— Tim Heckmann, L.P.T., A.T., C.
— Cindy McKnight, A.T., C.
— Paul Sparling, L.P.T., A.T., C.

ADVANCED TRAUMA LIFE SUPPORT COURSE

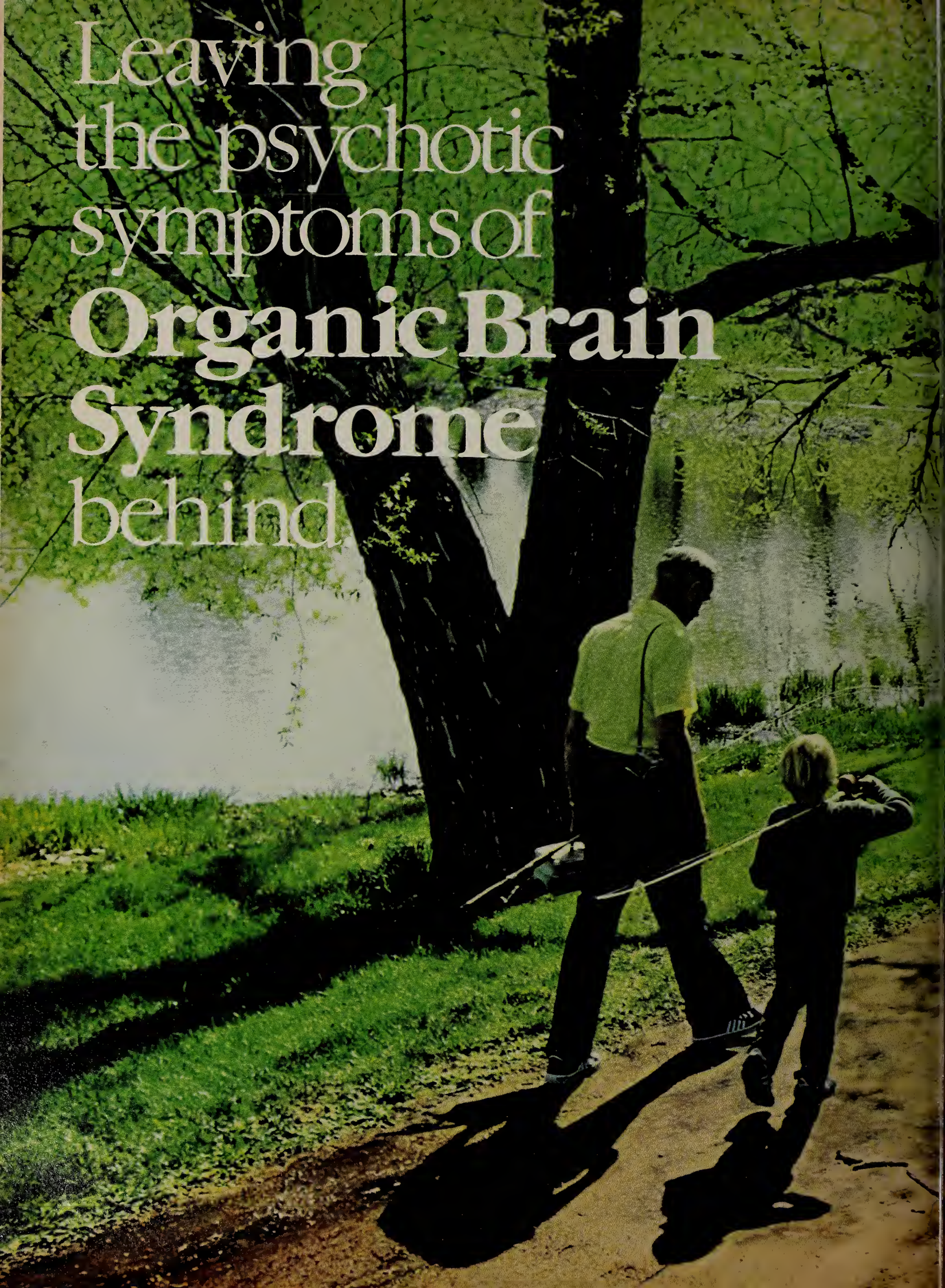
CME Hours: 16 Category I
Dates: Monday, May 21 and Tuesday, May 22
Places: Cincinnati Convention Center and Clarion Hotel
Times: Monday, 7:30 AM; Tuesday, 8:00 AM to 4:00 PM
Sponsor: Ohio Committee on Trauma, A.C.S.
Course Co-Directors
Richard B. Fratiane, M.D.
Chairman
Ohio Committee on Trauma, A.C.S.
Cleveland Metro Hospital

James Hurst, M.D.
Department of Surgery
University of Cincinnati

Fee: $300 (limited to 32 physicians)
Monday — May 21
7:30 AM-12:00 PM
Room 15, Cincinnati Convention Center
ATLS Lecture: Course overview and introduction to ATLS; Initial Assessment; Upper Airway Management; Shock; Thoracic Trauma; Abdominal Trauma.
12:00 PM-1:00 PM
Ivory B, Clarion Hotel — LUNCHEON
1:00 PM
Bus departs to University of Cincinnati for afternoon program
Afternoon program
Practical:
Animal Lab: Cricothyroidotomy; Peritoneal Lavage; Pericardiocentesis; Chest decompression/tube insertion.
Intubation
Anti-shock garment application
I.V./Shock Therapy
Tuesday — May 22
8:00 AM-9:45 AM
Room 25, Cincinnati Convention Center
ATLS Lecture:
9:45 AM-11:00 AM
Room 22, Convention Center
Three Skill Stations
11:00 AM-12:00 PM
Room 25, Convention Center
Lecture
12:00 PM-1:00 PM
Commodore Room, Clarion Hotel — LUNCHEON
1:00 PM-4:00 PM
Room 22, Convention Center
Four Patient Stations
Room 25, Convention Center
Examine Room

LECTURES
Head Trauma
Neck/Spinal Trauma
Extremity Trauma
Burns
Stabilization and Transport

continued on page 293


Leaving
the psychotic
symptoms of
Organic Brain
Syndrome
behind.



Effective

Treatment with Navane can produce improvement in psychotic symptoms such as hallucinatory behavior and unusual thought content as well as hostility, disorientation and depressive mood,[1,2] leaving the elderly patient more alert[2] and better able to participate in the activities of family life.

Well tolerated

Navane is generally well tolerated by elderly patients. Excessive sedation or drowsiness has been reported, but is uncommon.[1] Anticholinergic effects[3] and hypotension[4,5] are reported, but rarely. Should they occur, extrapyramidal symptoms can usually be readily controlled.

Navane®

(thiothixene) (thiothixene HCl)

Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
Concentrate 5 mg/ml · Intramuscular 2 mg/ml, 5 mg/ml

See following page for a brief summary of prescribing information.

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ROERIG Pfizer
A division of Pfizer Pharmaceuticals
at the forefront of psychopharmacology

Navane®
(thiothixene) (thiothixene HCl)

References: 1. Util TM, Unverdi C. Wohlrade J, et al: Drug therapy of psychosis associated with organic brain syndrome. Presented as a Scientific Exhibit at the American Public Health Association Centennial, Atlantic City, New Jersey, November 12-16, 1972. 2. Katz MM, Util TM: Video methodology for research in psychopathology and psychopharmacology. *Arch Gen Psychiatry* 31:204-210, 1974. 3. Ketai R: Psychotropic drugs in the management of psychiatric emergencies. *Postgraduate Medicine* 58:87-93, 1975. 4. Birkett DP, Hirschfield W, Simpson GM: Thiothixene in the treatment of diseases of the senium. *Curr Ther Res* 14:775-779, 1972. 5. Data on file at Roerig.

BRIEF SUMMARY OF PRESCRIBING INFORMATION
Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
(thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular: 2 mg/ml, 5 mg/ml
Contraindications: Navane (thiothixene) is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but the possibility should be considered.
Warnings: *Usage in Pregnancy*—Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration of Navane to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in Children—The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.
Precautions: An antiemetic effect was observed in animal studies with Navane, since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy, and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis) have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Neuroleptic drugs elevate prolactin levels; the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis; the available evidence is considered too limited to be conclusive at this time.

Intramuscular Administration—As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e. gluteus maximus) and the mid-lateral thigh.

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.
Adverse Reactions: *Note:* Not all of the following adverse reactions have been reported with Navane (thiothixene). However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used.

Cardiovascular effects: Tachycardia, hypotension, lightheadedness, and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines. The clinical significance of these changes is not known.

CNS effects: Drowsiness, usually mild, may occur although it usually subsides wtih continuation of Navane therapy. The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane (thiothixene). Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudo-parkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia: As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.



There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Undue exposure to sunlight should be avoided. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

Although not reported with Navane, evidence indicates there is a relationship between phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrome.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration.
Dosage and Administration: Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition. In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on once-a-day Navane therapy.

Usage in children under 12 years of age is not recommended because safe conditions for its use have not been established.

Navane Intramuscular Solution: Navane For Injection—Where more rapid control and treatment of acute behavior is desirable, the intramuscular form of Navane may be indicated. It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg/day. An oral form should supplant the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane (thiothixene) Capsules and Concentrate appear in the following paragraphs.

Navane Capsules: Navane Concentrate—In milder conditions, an initial dose of 2 mg three times daily. If indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg twice daily.

The usual optimal dose is 20 to 30 mg daily. If indicated, an increase to 60 mg/day total daily dose is often effective. Exceeding a total daily dose of 60 mg rarely increases the beneficial response.
Overdosage: Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, hypotension, disturbances of gait, or coma.

Treatment: Essentially is symptomatic and supportive. For Navane oral, early gastric lavage is helpful. For Navane oral and Intramuscular, keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors.)

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of the blood pressure.

If CNS depression is present and specific therapy is indicated, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Stimulants that may cause convulsions (e.g. picrotoxin or pentylenetetrazol) should be avoided. Extrapyramidal symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals

CME Courses

continued from page 289

PRACTICAL
Mr. HURT/Cervical Traction tongs
Extremity Immobilization
Spinal Immobilization
Initial Assessment — Practice/Test
Case Studies
Written Test

4:00 PM
Adjournment

The ATLS Courses have been specifically designed for the primary care physician, emergency department physician and surgeon.

COURSE OBJECTIVES

Upon completion of the ATLS course, the participant will be able to

I. Demonstrate concepts and principles of patient assessment.
II. Establish management priorities in a trauma situation.
III. Initiate primary and secondary management necessary, within the first hour of emergency care, for acute life threatening emergencies.
IV. Demonstrate the skills necessary in initial management of trauma victims:
- Initial assessment of victims with multiple injuries
- Application of Anti-Shock garment
- Initiation of intravenous therapy with CVP and shock management
- Adult/Infant intubation and nasotracheal intubation
- Cricothyroidotomy
- Pleural decompression and chest tube insertion
- Pericardiocentesis
- Peritoneal lavage
- Extremity and Spinal immobilization
- Head trauma management with application of cervical traction tongs

For further information, contact Education Department, Ohio State Medical Association.

UROLOGY

Date: Wednesday, May 23
Place: Room 5, Convention Center and Ivory B, Clarion Hotel
Time: 12 Noon to 5:00 PM
Sponsor: Ohio Urological Society
Schedule:
12 Noon-1:00 PM
Luncheon — Ivory B, Clarion Hotel
1:00-2:00 PM
Business Meeting
— Lester Persky, M.D., Cleveland, Presiding
2:00-5:00 PM
Ohio Urology Resident Forum
— Richard A. Memo, Moderator

Delegate and Alternate Schedule

continued from page 285

governed by Section 7, Chapter 5, of the OSMA Constitution and Bylaws as revised by the House of Delegates in May 1971.

**SPECIAL ORDER OF BUSINESS
(after-dinner break)
Installation of 1984-1985 Officers
Reports of Reference Committees
Resolutions Committee No. 1;
Resolutions Committee No. 2;
Resolutions Committee No. 3 and President's Address
Miscellaneous Business
Announcement
A. Burton Payne, M.D., Ironton
President
Unfinished Business
Adjournment

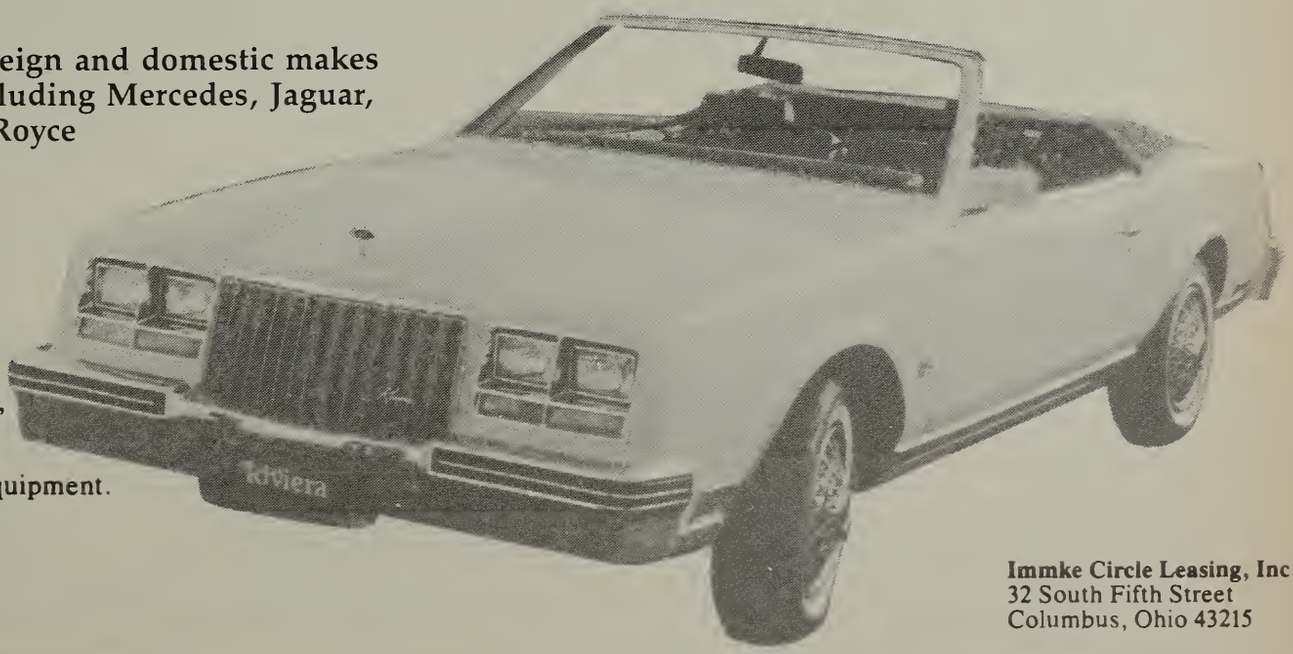
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Agency Reference

To find the PICO agent(s) in your area, consult the listing below.

AKRON

Frank B. Hall & Co. of Ohio, Inc.
425 West Market Street
Akron, Ohio 44303
(216) 535-2141

ASHTABULA

The Gluck Insurance Agency
2901 Market Street
Youngstown, Ohio 44507
Ohio toll-free: 800-362-6577

ATHENS

Earl E. Mathews, Inc.
8 North Court Street
Athens, Ohio 45701
(614) 593-5573

CANTON

Frank B. Hall & Co. of Ohio, Inc.
425 West Market Street
Akron, Ohio 44303
(216) 452-1366

CINCINNATI

Rudd-Pomery Agency
105 West Fourth Street
Cincinnati, Ohio 45202
(513) 721-7766

S.P. Agency, Inc.
1811 Losantiville
Cincinnati, Ohio 45237
(513) 531-8700

Wilder, Siegman & Associates, Inc.
906 Main Street
Cincinnati, Ohio 45202
(513) 381-3100

Thomas E. Wood, Inc.
1500 Carew Tower
Cincinnati, Ohio 45202
(513) 852-6339

CLEVELAND

Dennis Insurance Agency
150 East Sprague Road
Broadview Heights, Ohio 44147
(216) 526-5700

John M. Haas Insurance
26130 Lorain Road
North Olmsted, Ohio 44070
(216) 779-8300
24545 Sprague Road
Columbia Station, Ohio 44028
(216) 235-8585

R. Macknin Insurance Agency, Inc.
3681 Green Road
Beachwood, Ohio 44122
(216) 464-4080

Stockdale Insurance Agency
24600 Center Ridge
Suite 133, King James Office Park
Westlake, Ohio 44145
(216) 835-6950

United Agencies Inc.
1550 Hanna Building
Cleveland, Ohio 44115
(216) 696-8044

COLUMBUS

Neil Governor & Associates
1120 Morse Road
Columbus, Ohio 43229
(614) 846-0803

Grubers' Columbus Agency, Inc.
3040 Riverside Drive
Columbus, Ohio 43221
(614) 486-0611

The Johnson Insurance Agency
3029 Sullivant Avenue
Columbus, Ohio 43204
(614) 276-1600

McCaffrey Insurance Agency
921 Chatham Lane
Columbus, Ohio 43221
(614) 451-3808

Sokol Insurance Agency
3242 East Main Street
Columbus, Ohio 43213
(614) 235-1111

Tice, Inc.
250 East Broad Street
Columbus, Ohio 43215
(614) 224-1291

DAYTON

Baldwin & Whitney Agency, Inc.
7 East Fourth Street, Suite 924
Dayton, Ohio 45402
(513) 223-3181

ELYRIA

Humphrey & Cavagna
Insurance Agency
507 Broad Street
Elyria, Ohio 44035
(216) 322-5477
Lorain: (216) 244-3228

IRONTON

Hurley Insurance Agency
511 Kemp Avenue
P.O. Box 636
Ironton, Ohio 45638
(614) 532-8712
Also serving Gallia and
Scioto Counties

KENT

W.W. Reed & Son
141 East Main Street
Kent, Ohio 44240
(216) 673-5838

LIMA

Stolly Insurance
973 West North Street
Lima, Ohio 45805
(419) 227-2570

MEDINA

Dennis Insurance Agency
9859 Pawnee Road
West Salem, Ohio 44287
Cuyahoga County: (216) 526-5700
Medina County: (216) 948-2345

Humphrey & Cavagna
Insurance Agency
507 Broad Street
Elyria, Ohio 44035
(216) 322-5477
Cleveland: (216) 734-0977

NEWARK

Madison-Collins Insurance Agency
180 Hudson Avenue
Newark, Ohio 43055
(614) 345-9741

PLYMOUTH

Utz Insurance Agency
P.O. Box 167
Plymouth, Ohio 44865
(419) 687-6252

SPRINGFIELD

Wallace and Turner
616 North Limestone Street
Springfield, Ohio 45501
(513) 324-8492

STEUBENVILLE

Sanford W. Berman Agency
423 Washington Street
Steubenville, Ohio 43952
(614) 282-9736

TOLEDO

Brooks Insurance Agency, Inc.
1120 Madison Avenue
Toledo, Ohio 43624
(419) 243-1191

Palmer-Blair Insurance Agency Co.
605 Spitzer Building
Toledo, Ohio 43604
(419) 248-4141

WARREN

The Gluck Insurance Agency
2901 Market Street
Youngstown, Ohio 44507
Ohio toll-free: 800-362-6577

WILMINGTON

Bacon & Associates Agency Inc.
683 N. Lincoln Street
P.O. Box 111
Wilmington, Ohio 45177
(513) 382-6695

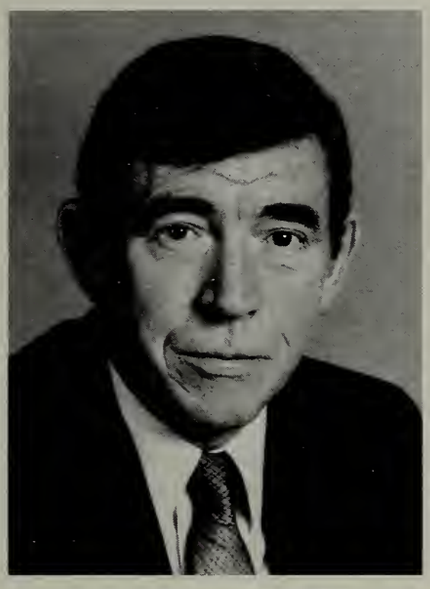
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(216) 788-6577
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OMPAC LUNCHEON

Saturday, May 19, 1984
Grand Ballroom Foyer/Grand Ballroom A&B
Clarion Hotel, Cincinnati, Ohio

Reception: 11:15 A.M. **Luncheon: 12 Noon**



DOUGLAS KIKER

Douglas Kiker
"A View From Washington"

Douglas Kiker is one of the nation's best known and most widely respected television news correspondents. His vast weekly exposure on NBC Magazine with David Brinkley has made him very much in demand by business groups, colleges and universities throughout the country.

As NBC's national political correspondent, he followed every major candidate in the last five Presidential campaigns. He has covered every national political convention since 1964.

As Washington correspondent for NBC's Today Show, his interviews with national and international figures have been seen by millions of viewers.

Douglas Kiker was born and raised in Griffin, Georgia and is a graduate of Presbyterian College. He is the author of two novels and his articles have appeared in The Atlantic Monthly, Harper's, The Yale Review and The New Yorker, among others.

OSMA'S RIVERBOAT CRUISE

SATURDAY, MAY 19, 1984

Explore the beautiful Ohio River and experience the romance of the river on the Sunset and Moonlight Cruise of the *BECKY THATCHER.*

OSMA has chartered the *BECKY THATCHER* for its own party for Saturday evening, May 19, 1984. Bus service will be available from the Clarion Hotel and will deliver you to the dock area for your 3 hour cruise, and return you to the hotel at the end of the evening. A complete dinner cruise with cocktails and hors d'oeuvres. A 5-piece Dixieland Jazz Band will play for your listening and dancing pleasure.

SCHEDULE

6:15 p.m.	Bus leaves Clarion Hotel to Boatdock area
6:30 p.m.	Boarding time of *BECKY THATCHER*
8:00 p.m.	Dinner
7-10 p.m.	Cruise time

OSMA SOCIAL FUNCTION RESERVATIONS
1984 ANNUAL MEETING

PLEASE PRINT

NAME _____

ADDRESS _____

CITY, STATE _____ ZIP _____

TELEPHONE NO. ( ) _____

MAKE CHECKS PAYABLE TO: OSMA

Mail to: Department of Education: Specialty
Society and Meeting Management
Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215

Saturday, May 19, 1984

	No. of tickets	Amount
OMPAC Luncheon	_____	$_____
($15 per person)		
Riverboat Party *Becky Thatcher*	_____	$_____
($30.00 per person)		
TOTAL		$_____

County Society Officers, Executive Directors and Meeting Dates

First District

Councilor: **John E. Albers, M.D.**, 2350 Auburn Ave., Cincinnati 45219.

ADAMS: David E. Pixley, M.D., President, 154 E. Elliott Ave., Peebles 45660; Jose L. Basa, M.D., Secretary-Treasurer, 17907 State Route 247, Seaman 45679. Second Tuesday.

BROWN: Walter Ferris, M.D., President, 614 S. High St, Mt. Orab 45154; William H. Bentson, M.D., Secretary-Treasurer, 14 N. Second St., Ripley 45167. Third Tuesday alternated with fourth Tuesday.

***BUTLER:** George T. Manitsas, M.D., President, 1380 N.W. Washington Blvd., Hamilton 45013; James P. Baden, M.D., Secretary-Treasurer, 347 Park Ave., Hamilton 45013; Frances L. Bachman, Executive Secretary, 111 Buckeye St., P.O. Box 3216, Hamilton 45013, 513/893-1410. Fourth Wednesday, January through May, October and November.

CLERMONT: Jonathan H. Head, M.D., President, 134 Cleveland Ave., Milford 45150; William Blake Selnick, D.O., Secretary-Treasurer, Second & E. Loveland Aves., Loveland 45140. Third Wednesday except July and August.

CLINTON: H. Chung Tai Hu, M.D., President, 891 W. Locust St., Wilmington 45177; Janet Gick Matrka, M.D., Secretary-Treasurer, 222 W. Main St., Wilmington 45177; Marilyn S. Walker, Executive Secretary, 119E State Route 122, Lebanon 45036, 513/382-6611 (lab). Fourth Tuesday except July and December.

***HAMILTON:** William H. Gates, M.D., President, 5566 Cheviot Rd., Cincinnati 45247; Kathryn A. Weichert, M.D., Secretary, 9425 Holly Hill, Cincinnati 45243; William J. Galligan, Executive Director, 320 Broadway, Cincinnati 45202, 513/421-7010. Second Tuesday.

HIGHLAND: No active county medical society.

WARREN: Ray Simendinger, M.D., President, 901 N. Broadway, Lebanon 45036; Jan D. Knisely, M.D., Secretary, 1618 Deerfield Rd., Lebanon 45036. Second Tuesday.

Second District

Councilor: **Herman I. Abromowitz, M.D.**, 226 Troy St., Dayton 45404.

CHAMPAIGN: J. Steven Polsley, M.D., President, 160 Eastview Dr., Urbana 43078; Ned Saini, M.D., Secretary-Treasurer, 900 Scioto St., Urbana 43078. Second Wednesday.

CLARK: Joel Vanderglas, M.D., President, 7185 Dayton Rd., Enon 45323; Paul Andorfer, M.D., Secretary, 4465 E. National Rd., Springfield 45505; Colleen Buscemi, Executive Secretary, 34 W. High St., Room 710, Springfield 45502, 513/324-8618. Third Monday.

DARKE: Charles Reier, M.D., President, 955 Sunset Dr., Greenville 45331; Stephen Brewer, M.D., Secretary, 552 S. West St., Versailles 45380. Third Tuesday.

GREENE: Rajendra Patel, M.D., President, 1237 N. Monroe Dr., Xenia 45385; William Duteil, D.O., Secretary-Treasurer, 1134 N. Monroe Dr., Xenia 45385; Judy Khoii, Executive Secretary, 428 Wilson Dr., Xenia 45385, 513/376-3783. Four meetings per year.

***MIAMI:** A. Robert Davies, M.D., President, 530 Crescent Dr., Troy 45373; Ramen Das, M.D., Secretary, 624 Park Ave., Piqua 45356. First Tuesday.

MONTGOMERY: Harold G. Kelso, Jr., M.D., President, 330 N. Main St., Dayton 45459; Emil W. Peterson, M.D., Secretary, 3535 Southern Blvd., Dayton 45429; Richard G. Tapia, Executive Director, 40 S. Perry St., #100, Dayton 45402, 513/223-0990. Second Thursday except July and August.

PREBLE: John D. Darrow, M.D., President and Secretary-Treasurer, 228 N. Barron St., Eaton 45320.

SHELBY: Edward Link, M.D., President, Third & Michigan Sts., Sidney 45365; Florencio Reyes, M.D., Secretary-Treasurer, 430 Fourth Ave., Sidney 45365. Second Tuesday.

Third District

Councilor: **Thomas R. Leech, M.D.**, 1700 W. Market St., Lima 45805.

***ALLEN:** Roger D. Jenkins, M.D., President, 850 Bellefontaine Ave., Lima 45804; Roger L. Terry, M.D., Secretary-Treasurer, 1220 E. Elm St., #110, Lima 45805; Will Wolf, Executive Secretary, P.O. Box 1647, Lima 45802, 419/228-3335. Third Tuesday, September through May.

AUGLAIZE: Thomas C. Dozier, D.O., President, 112 Court St., St. Marys 45885; Robert Herman, M.D., Secretary-Treasurer, 1007 W. Auglaize St., Wapakoneta 45895. First Thursday, January, March, May, September and November.

CRAWFORD: Don E. Ingham, M.D., President, 270 Portland Way S., Galion 44833; Theodore Ebner, M.D., Secretary-Treasurer, P.O. Box 704, Galion 44833. Meetings when called.

HANCOCK: William Alcott, M.D., President, 1818 Chapel Drive, #A, Findlay 45840; Jack G. Hendershot, Jr., M.D., Secretary, 400 W. Sandusky St., Findlay 45840. Third Tuesday.

HARDIN: Filmore A. Riego, M.D., President, 210 W. Columbus St., Kenton 43326; Andrea C. Chang, M.D., Secretary-Treasurer, 75 Washington Blvd., Kenton 43326. Second Tuesday.

LOGAN: Roger J. Kauffman, M.D., President, Oakhill Medical Center, State Route 68 North, West Liberty 43357; David Eubanks, M.D., Secretary-Treasurer, 4879 State Route 68 South, West Liberty 43357.

***MARION:** Jose Albernaz, M.D., President, 807 Vernon Heights Blvd., Marion 43302; Vernon Nichols, M.D., Secretary-Treasurer, Marion General Hospital, McKinley Park Dr., Marion 43302. First Tuesday, October through May.

MERCER: Robert W. Albers, M.D., President, 906 N. Cedar St., Coldwater 45828; George H. McIlroy, M.D., Secretary-Treasurer, 123 E. Fayette St., Celina 45822. Third Tuesday, September through May.

SENECA: John F. Vela, M.D., President, 71 St. Francis Ave., Tiffin 44883; A.M. Desai, M.D., Secretary-Treasurer, 485 W. Market St., Tiffin 44884. Third Tuesday except July, August and December.

VAN WERT: Robert C. Adams, M.D., President, 140 Fox Road, P.O. Box 232, Van Wert 45891; Wilmer Iler, M.D., Secretary-Treasurer, Medical Arts Bldg., 140 Fox Road, Van Wert 45891. First Tuesday.

WYANDOT: Kyu Park, M.D., President, 8099 Wyandot County Road 200, Upper Sandusky 43351; Nasser Zohoury, M.D., Secretary-Treasurer, 132 E. Wyandot St., Upper Sandusky 43351; Gloria Orians, A.R.T., Executive Secretary, Wyandot Memorial Hospital, 885 N. Sandusky Ave., Upper Sandusky 43351, 419/294-1941, Ext. 32. Second Tuesday.

Fourth District

Councilor: **Benjamin H. Reed, M.D.**, 730 Burr Road, Wauseon 43567.

DEFIANCE: Steve Noparat, M.D., President, P.O. Box 392, Defiance 43512; Robert Shaw, M.D., Secretary-Treasurer, 340 Northwood Drive, Defiance 43512. Second Tuesday.

FULTON: David A. Thompson, M.D., President, 405 E. Lutz Rd., Archbold 43502; Estela T. Miquiabas, M.D., Secretary-Treasurer, 725 S. Shoop Ave., Wauseon 43567. Second Tuesday, quarterly.

HENRY: Wilson J. Stough, M.D., President, 515 Avon Pl., Napoleon 43545; A.A. Lauengco, M.D., Secretary-Treasurer, Belton & Marion Sts., Hamler 43524. Meetings when called.

LUCAS: James A. Jagodzinski, M.D., President, 3939 Monroe St., Toledo 43606; Su-Pa Kang, M.D., Secretary, 3900 Sunforest Ct., Toledo 43623; Lee F. Wealton, Executive Director, 4428 Secor Road, Toledo 43623, 419/473-3200. Fourth Tuesday.

OTTAWA: John F. Bodie, M.D., President, 1130 Lee Avenue, Port Clinton 43452; Barry R. Cover, M.D., Secretary-Treasurer, 118 E. Perry St., Port Clinton 43452. Second Thursday.

PAULDING: David Fanney, M.D., President, Payne Clinic, Payne 45880; Robert Todaro, M.D., Secretary-Treasurer, Route 2, Box 1271, Paulding 45879. Third Monday.

PUTNAM: Earl Dewitt, M.D., President, 240 E. Sycamore St., Columbus Grove 45830; Charles Kidd, M.D., Secretary-Treasurer, Box 256, Kalida 45853. First Tuesday.

SANDUSKY: Samuel R. Lowery, M.D., President, 1236 Napoleon St., Fremont 43420; John L. Zimmerman, M.D., Secretary-Treasurer, Memorial Hospital, Fremont 43420. Patsy J. Reed, Executive Secretary, Memorial Hospital of Sandusky County, Fremont 43420, 419/332-7321. Last Thursday.

WILLIAMS: Clarence Bell, Jr., M.D., President, 935 Snyder Ave., Montpelier 43543; Richard L. Hess, M.D., Secretary-Treasurer, 442 W. High St., Bryan 43506; Rebecca Cape, Executive Secretary, Bryan Medical Group, Inc., 442 W. High St., Bryan 43506, 419/636-4517. Third Tuesday, January, March, May, September and November.

WOOD: Douglas S. Hess, M.D., President, 1362 Conneaut Ave., Box 370B, Bowling Green 43402; Edelbert J. Kuebeck, M.D., Secretary-Treasurer, 1052 W. Wooster St., Bowling Green 43402. Second Tuesday.

Fifth District

Councilor: **Donavin A. Baumgartner, Jr., M.D.,** St. Luke's Hospital, 11311 Shaker Blvd., Cleveland 44104.

ASHTABULA: Guy V. Jeanblanc, M.D., President, 430 W. 25th St., Ashtabula 44004; Abdel B. Marcus, M.D., Secretary-Treasurer, 1914 W. Prospect Rd., Ashtabula 44004; Amy Housel, Executive Secretary, P.O. Box 1772, Ashtabula 44004, 216/998-3111. Second Tuesday, February, April, September and November.

***CUYAHOGA:** Richard B. Fratianne, M.D., President, 4996 Delevan Dr., Cleveland 44124; Daniel A. Deutschman, M.D., Secretary-Treasurer, 11201 Shaker Blvd., Cleveland 44104; Robert A. Lang, Ph.D., Executive Director, 11001 Cedar Rd., 6th Floor, Cleveland 44106, 216/229-2200. Board of Directors meets second Tuesday.

GEAUGA: Patrawadee Duangjak, M.D., President, Geauga Community Hospital, P.O. Box 249, Chardon 44024; Wayne Risius, M.D., Secretary-Treasurer, 13214 Ravenna Rd., Chardon 44024; Margaret Pace, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024, 216/286-6131. Second Thursday, January, April, September and November.

LAKE: Bela Ballo, M.D., President, 7259 Eagle Rd., Willoughby 44094; J. Thomas Leininger, M.D., Secretary-Treasurer, 18599 Lakeshore Blvd., Euclid 44119; Janice A. Vargo, Executive Secretary, Lake County Memorial Hospital, 71 E. High St., Painesville 44077, 216/942-9135. February, May, September and November.

Sixth District

Councilor: **J. James Anderson, M.D.,** 5204 Mahoning Ave., Suite 103, Youngstown 44515.

COLUMBIANA: Robert Bakondy, D.O., President, 1048 E. State St., Salem 44460; Dardo S. Torti, M.D., Secretary-Treasurer, 2360 S. East Blvd., Salem 44460; Pearl Koenreich, Executive Secretary, 530 Hawley Ave., Salem 44460, 216/337-8859. Third Tuesday.

MAHONING: Glenn J. Baumblatt, M.D., President, 510 Gypsy Lane, Youngstown 44504; Karl F. Wieneke, M.D., Secretary, 64 Ridge Ave., Youngstown 44502; Robert B. Blake, Executive Director, 1005 Belmont Ave., #245, Youngstown 44504, 216/747-4956. Third Tuesday, January, March, May, September, November and December.

STARK: William Martin, M.D., President, 845 Eighth St., N.E., Massillon 44646; Jorge Esguerra, M.D., Secretary-Treasurer, 2600 Sixth St., S.W., Canton 44701; Nancy L. Adams, Executive Secretary, 4150 Belden Village St., N.W., Canton 44718, 216/492-3333. Second Thursday, October through April.

TRUMBULL: Nigel K. Newman, M.D., President, 3921 E. Market St., Warren 44484; B. Joseph Tabet, M.D., Secretary-Treasurer, 340 Ridge Rd., Newton Falls 44444; Doris Dean, Executive Secretary, 280 N. Park Ave., P.O. Box 186, Warren 44482, 216/394-4556. Third Wednesday.

Seventh District

Councilor: **H. Judson Reamy, M.D.,** 931 Fourth St., N.W., New Philadelphia 44663.

BELMONT: Nepomuceno Dario, M.D., President, 211 Main St., Bridgeport 43912; Nermin D. Lavapies, M.D., Secretary-Treasurer, 1220 Hughes Ave., Martins Ferry 43935. Third Thursday, February through April, September through December.

CARROLL: Carl A. Lincke, M.D., President, 159 Second St., S.W., P.O. Box 5, Carrollton 44615; Nan M. Bissell, M.D., Secretary-Treasurer, 450 S. Lisbon St., P.O. Box 338, Carrollton 44615. Third Tuesday.

COSHOCTON: Jerold A. Meyer, M.D., President, 404 S. 15th St., Coshocton 43812; Richard Emmons, M.D., Secretary-Treasurer, 646 Chestnut St., Coshocton 43812. Second Tuesday.

HARRISON: Ajit S. Modi, M.D., President, R.D. #1, Cadiz 43907; Siripurapu R. Prasad, M.D., Secretary-Treasurer, Main St., Box 323, Jewett 43986. Second Tuesday.

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** These counties change officers between April and October.*

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"2. Doe J, Roe RX: How to go about it. Ohio State MJ 13:24-30, 1920"

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A New Look at the Homeless

By Susan Porter

Today, the relationship between homelessness and mental illness is a speculative one, at best; however, a study recently undertaken by the Ohio Department of Mental Health may soon provide some answers.

The study is being funded through a $160,000 grant from the National Institute of Mental Health (NIMH) and is the first systematic study of homelessness ever done on a statewide basis, according to Dee Roth, chief of the office of program evaluation and research at ODMH.

Its purpose is to determine how many homeless people have previously had contact with the mental health system, as well as whether or not these individuals are still in need of services. "This data will give some indication about how community support services work and will assist us in understanding if discharge policies result in an increase in the homeless population," according to Roth.

The study also aims to determine whether those homeless people with no previous contact with the mental health system are in need of these services. Speculation is that many are, says Roth, yet, "there is no comprehensive research on this issue that would define the scope of the problem for policymakers or would point to appropriate solutions."

While the study will be confined to some 20 counties in Ohio, the findings are expected to be used nationwide. "One of the reasons we were chosen for the grant is that Ohio is a kind of microcosm of the country in its proportion of urban, rural and mixed areas," says Roth. "We are therefore assuming that we will be able to generalize our results nationally."

The ODMH project also was selected for NIMH funding because of its proposal to include both urban and rural areas in its study. "As we started to think through this issue of homelessness, we began to realize that they're not all staying in big cities or public shelters," says Roth. "Some may be living in cardboard boxes or abandoned shacks; others in empty buildings, old hotels or flophouses where they may move every 20 days or so. Most past studies have been limited, focusing on large public shelters in places like New York City. Our feeling is that we are looking at a real unknown — that there is homelessness in the rural and mixed areas, as well as in the urban areas."

Therefore, for purposes of this study, Ohio has been divided into five regions, and four counties have been selected from each: one urban county, a mixed urban/rural county, and two rural counties.

The project is being undertaken in four phases. Part one, which started after the grant was received last November, is already complete. The remaining three phases are expected to be completed by the end of 1984.

In the first phase, 250 "key informants," including social workers, county welfare directors, police, shelter directors, mental health personnel, clergy and even reporters were questioned, indepth, about their knowledge of and contacts with the homeless. The interviews had a two-fold purpose, says Roth; the first was to locate homeless individuals to be

interviewed in Phase II. The second was to determine how best to approach and interview these "street people."

Phase II, the major component of the research project, was scheduled to begin in March and to run through the end of the summer, thereby allowing the homeless to be sought out and interviewed in a variety of seasonal living conditions. It consists of 1,000 face-to-face interviews with homeless individuals by researchers carefully chosen from each region for their expertise in dealing with persons with psychiatric problems, as well as "street people." Among these are researchers from Youngstown State University, Case Western Reserve, the University of Cincinnati, the University of Toledo and the Ohio State University.

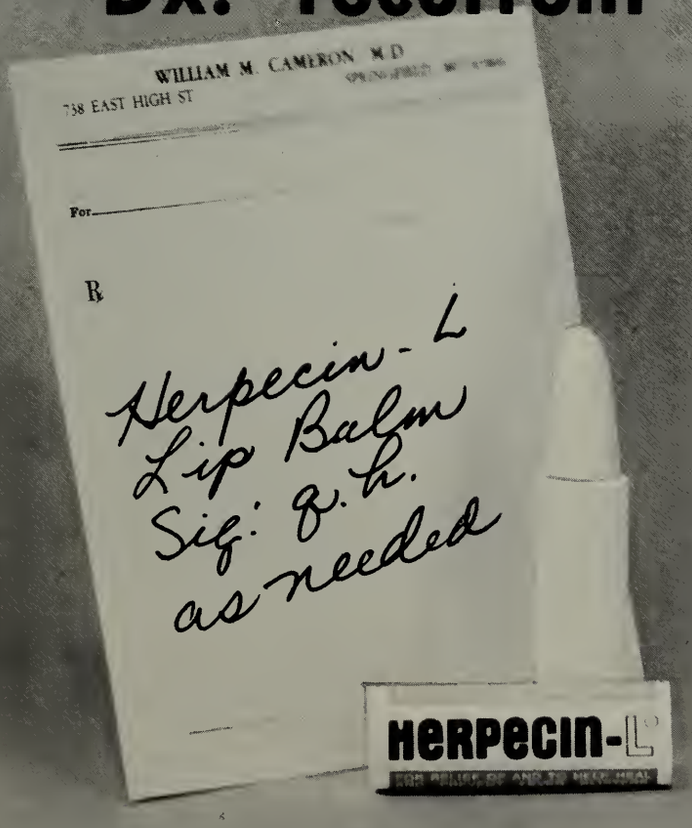
In the third phase of the project, says Roth, community mental health agencies throughout the state will be contacted in an effort to trace a sampling of patients who have been released from state institutions, in order to determine if they have permanent living conditions and if their mental health needs are currently being met. Phase IV will study those recently admitted to hospitals to see if homelessness was a precipitating factor in their admissions.

"As we started to think through this issue of homelessness, we began to realize that they're not all staying in big cities or public shelters . . . Our feeling is that we are looking at a real unknown — that there is homelessness in the rural and mixed areas, as well as in the urban areas."

The study may not answer all questions regarding possible links between mental illness and homelessness, says Roth. But at the very least it should provide a data base which will allow government officials and health care professionals, alike, the opportunity to do a more factual analysis of the situation. **OSMA**

Susan Porter is Assistant Editor of the Ohio State Medical Journal.

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some interpretations of that information as the basis upon which county, state, and specialty societies can develop their own perspectives on the future environment of medicine.

Two factors should be balanced against the view that further evolution in the environment of medicine is likely in the near future:

1. **There is an inherent tendency in undertaking a study of the environment to search for and emphasize the forces for change. The reader should keep in mind that there are strong forces that will resist radical changes in the environment of medicine. Both the public and physicians express strong support for almost all aspects of the current medical care system, except for the "costs" of that system. All the major participants in the health sector consistently express satisfaction and pride in the quality of medical care in this country.**
2. **There is less than complete certainty about the ramifications of many of the environmental trends identified and analyzed in this report. There is even less certainty about how various environmental trends are likely to interact with each other. It is possible that some environmental trends may be more positive than expected and that some trends will completely offset others. Again, the reader is encouraged to embrace healthy skepticism about accepting the view that rapid change in the environment of medicine is inevitable. Even if change in the environment is inevitable, history demonstrates that individuals and systems usually prove to be more resilient than expected.**

Finally, some of the environmental changes discussed in this report may appear to be "threatening" to both physicians and organized medicine. The Council believes that some trends do represent "threats" but also believes that they represent "opportunities." They represent opportunities for forward-thinking physicians to prosper by capitalizing on environmental change. They represent opportunities for medical organizations to demonstrate to physicians and others the importance and value of their activities. They represent opportunities for physicians and organized medicine to take the initiative in designing the future environment of medicine for the benefit of the public and the profession. It is the hope of the AMA's Council on Long Range Planning and Development that the information in this report will aid physicians and organized medicine in preparing for and shaping the future environment of medicine. **OSMA**

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The Peat-Marwick Report Examined

Reflections on Ohio's Malpractice Climate

By C. Douglass Ford, MD

Author's note:

The Task Force on Professional Liability selected the national public accounting firm of Peat, Marwick & Mitchell to conduct the analysis and their report has now been published. In this article I wish simply to append some thoughts and observations to that report.

These comments are prompted by my personal review of the Peat, Marwick report and have not been reviewed or approved by either the Task Force on Professional Liability or the Council of OSMA.

I have some thoughts about the Peat-Marwick "Analysis of Medical Malpractice Insurance Providers in Ohio," published in the March issue of the OSMA *Journal*. My request (approved by Council) for this analysis was prompted by the deteriorating environment of medical professional liability litigation and by the totally implausible increases in such insurance premiums experienced in other states. I was authorized by Council to request the OSMA Task Force on Professional Liability to commission a reputable accounting firm, not in the employ of PICO or of the OSMA, to analyze those eight insurance companies which sell medical professional liability insurance to Ohio's physicians. The goal of the Peat-Marwick report was to inform OSMA members about the financial stability of these eight carriers. The stability of the market (availability of policies) and the cost of such policies (stability of premiums) is very much a function of the financial condition of the eight carriers (adequate reserves, adequate premiums, adequate surplus, adequate reinsurance, etc.) who sell policies in the Ohio market.

Because the Medical Protective Company, the Ohio Hospital Insurance Company and PIE Mutual declined to participate in this analysis, the analysts based their report with respect to those companies upon data available in public documents in the Ohio Department of Insurance, Best's Reports, and such. This limitation potentially diminished the depth of the analysis, but the pitfall of comparing companies with differing data was avoided.

The analysis, as summarized for you in last month's *Journal*, involved tests of loss reserves and the results of the National Association of Insurance Commissioners (NAIC) tests. They analyzed the reinsurance arrangements as reported in these public documents, and they reported on the ratings of some of the companies which reinsure these eight companies. Lastly, they analyzed the existing rates (1982) and class groupings. The entire report (70 plus pages) can be obtained by any OSMA member for a nominal fee.

First, I will attempt to translate the argot of the insurance world and provide a graphic depiction of some of the numerical tables. You should understand that casualty insurance is a mechanism of pooling monies (premiums) from members of a group (physician insureds) who are exposed to a common risk (liability for professional acts). Then, individuals in that group, who become defendants in litigation alleging medical malpractice, turn to that fund of pooled premiums (claims) to defray the costs of defense and of any judgements assessed to them by the courts (loss expense and losses). The company has the right to set premiums by assessing the risks assumed (actuarial analysis) and they have the right to accept or reject applicants who wish to purchase insurance from that company as well as the right to set the limits of the insurance (underwriting).

When the company becomes aware of a claim, monies are set aside to defray the costs of defense of the insured and to pay the loss which might occur (loss reserves) for each policy year. By experience, the company will anticipate future claims which are as yet unreported to the company (Incurred But Not Reported — "IBNR"), and set aside funds for these expenditures each policy year. IBNR is an estimate of future losses.

Because of the time it takes to settle claims, the losses and their attendant expenses accumulate much more slowly in professional liability actions than in other types of casualty insurance (the "long tail").

The companies invest the premium dollars, seeking additional income. After several years — more, now, in Ohio as a result of the Ohio Supreme Court's decision adopting the

"discovery rule," with regard to the Statute of Limitations — the insurer can determine whether or not the premium charged was adequate to cover the losses, and their attendant expenses was adequate (profit or loss).

"Surplus" — monies accumulated by underwriting profits and by other uncommitted income — provides the necessary cushion for defraying unexpected losses.

Reinsurance is an "aid to surplus" in that, in return for a portion of the policy premium (ceded premium), losses in excess of a predetermined amount on one or more policies are paid by the reinsurer. The amount of ceded premium and the level of risk assumed by the reinsurer are negotiated for each policy year (the reinsurance treaty). In some treaties, the amount of ceded premium varies upward with the severity of losses; while in others, the ceded premium is fixed for that policy year, regardless of the losses incurred by the reinsurer.

LOSS RESERVE ANALYSIS:

Analysis of losses and of loss reserves showed that three companies had ratios of paid losses plus loss expenses to losses incurred which were higher than the average for the first and for the second year's experience.

Ohio Hospital Insurance Company's (OHIC) increased ratios were attributed to faster reporting of claims by their insureds (mainly hospitals) than by the insureds of the other companies (mainly physicians). St. Paul's writes "claims made" policies (as opposed to "occurrence" policies). This type of policy nearly eliminates IBNR, a characteristic which shortens claims to settlement time. PIE Mutual pays its legal defense expenses in the first year of the policy. By pre-paying these expenses, the ratio to earned premium increases to 20%-25%. Peat Marwick *estimates* that PIE Mutual has expended about $4,000,000 (an amount which exceeds the company's surplus) for future legal defense (as of 1981). None of these aberrant ratios were thought to be indicative of inadequate reserving for losses; but prepayment of legal defense costs was termed "unusual within the industry." PIE Mutual has "an exposure" in the event that their legal firms default on these purchased obligations.

The NAIC "early warning" tests were designed to alert State Insurance Departments that a company might be in financial difficulty. The Ohio Department of Insurance regulates all aspects of all types of insurance sold in Ohio. They examine the financial and required statistical reports of every company operating in Ohio. Since most State Departments do not have the staff or the funds to examine every company "in depth," the NAIC ratios are designed to pinpoint companies which may be financially troubled. This assists the State Departments in focusing their investigative resources. The "usual range" (normals) for each of these eleven ratios are determined by surveying the ratios of companies which have failed, and identifying those results which most likely allowed a failing company to be differentiated from a healthy one.

If a casualty company, licensed in Ohio fails, its policy holders in Ohio are protected by the Ohio Guarantee Association (OGA) — an association of all Ohio casualty insurers established by the legislature. The maximum claim payment by the OGA cannot exceed $300,000 or the policy limits, whichever is lower. Claims in existence prior to a court's decree that the company is insolvent are not honored by the OGA. The same is true for claims submitted during the 30 days after the decree. Thus the OGA might not provide adequate protection for a physician policyholder whose company fails. Happily, none of the companies which write professional liability insurance in Ohio were found to be in that condition.

Peat Marwick reports that the ratio of premium to surplus (test one of the NAIC) is the most common measurement of a company's "Solidity." The NAIC "usual range" is 3:1 (or 300%) or better. This means that a maximum of $3.00 of premium can be "safely" collected for each dollar of surplus. Since unexpected losses are defrayed with surplus funds, a company which maintains a low ratio reduces the number of policies it can sell (the dollars of premium it can collect) than it could with a higher ratio. However, the higher the ratio of premium to surplus, a given dollar amount of unexpected losses potentially commits a greater percentage of surplus funds than the same loss would, were that ratio lower.

According to Peat Marwick, companies which sell volatile lines of insurance, such as medical malpractice, require more surplus per dollar of premium (a lower ratio). They note that the Premium to Surplus ratio can be improved (made lower) with reinsurance (Surplus Aid). As accountants say: "Even though there is no 'generally accepted theory' of the best ratio, it is valid to compare the ratios of companies in the same business."

Appendix A of the report discusses each of the eleven NAIC tests and their interpretations. I will limit my discussion to those tests in which one or more of the eight companies exceeded the "usual range."

Test 2
Change in Writings

Major decreases in writings indicate a decline in the number of policy holders — which reduces income and makes actuarial functions increasingly unprecise. Major increases in writings may be due to entry into new markets or it may be due to the company increasing cash in flow (by reducing premium) to meet loss payments (because of inadequate surplus). It may also reflect a healthy company with increased penetration of its existing market.

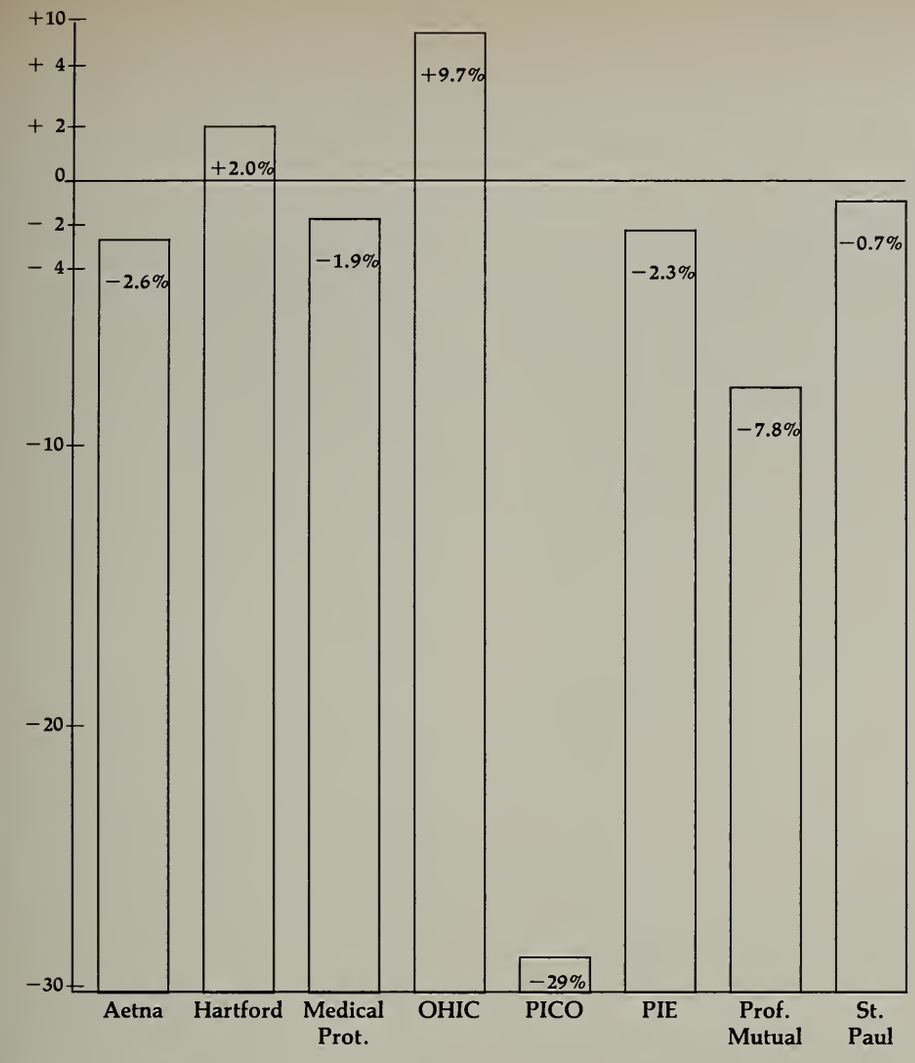
Test 4
Two Year Adjusted Underwriting Ratio

This ratio is a measure of a company's underwriting profitability. In 1981, investment income was not included in the calculation. In 1982, it was. Results above 100 indicate an underwriting loss; while those below 100 indicate an underwriting gain.

Test 6
Change in Surplus

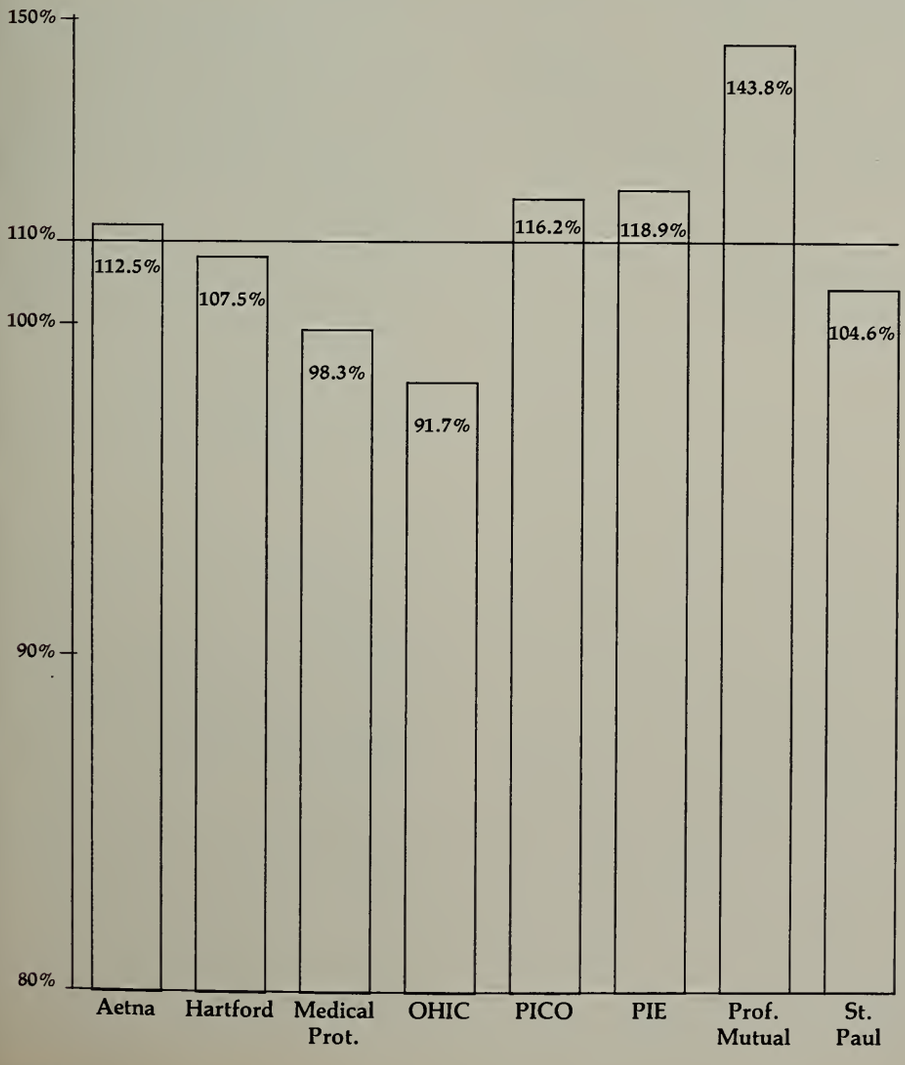
The change in surplus basically measures a company's improvement or deterioration in its financial condition. A significant decrease in surplus is a cause for concern. Major increases may be a sign of instability or may be related to a change in ownership of the company.

CHANGE IN WRITINGS 1981



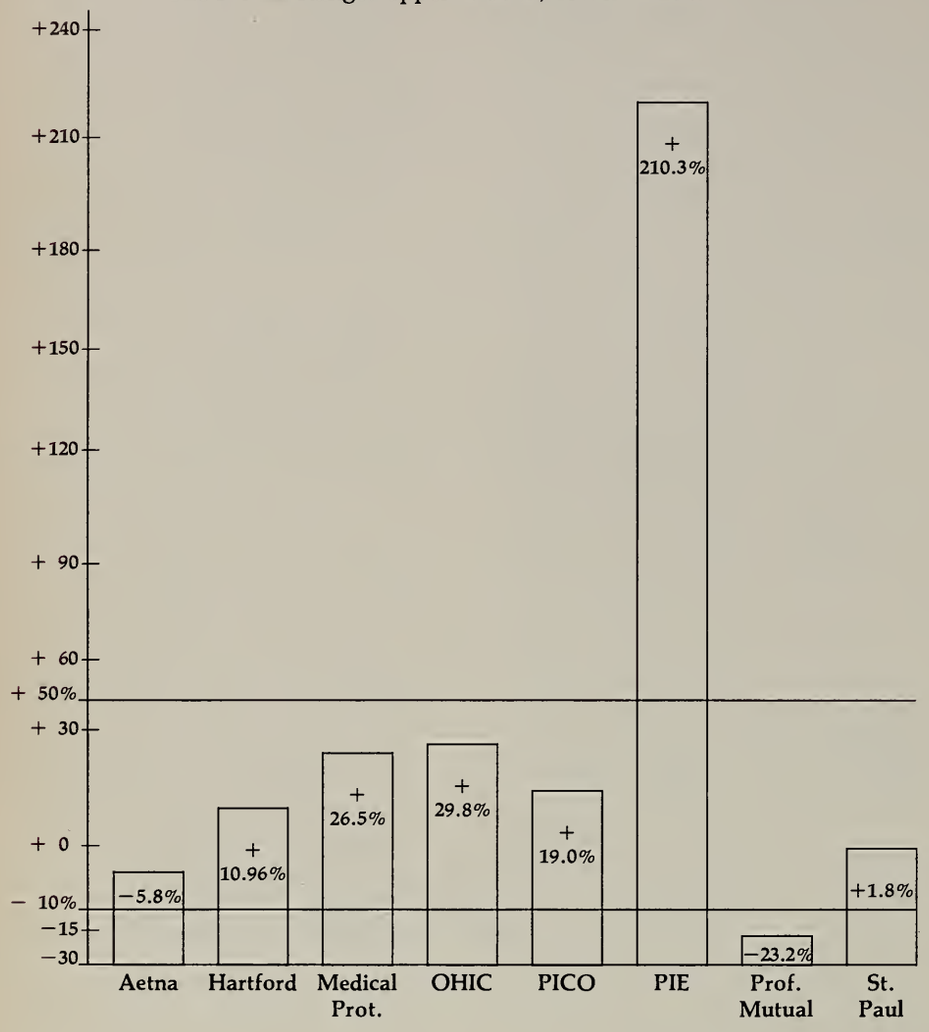
TWO YEAR OVERALL OPERATING-RATIO 1981

Test 4 — Range: upper 110%, lower none



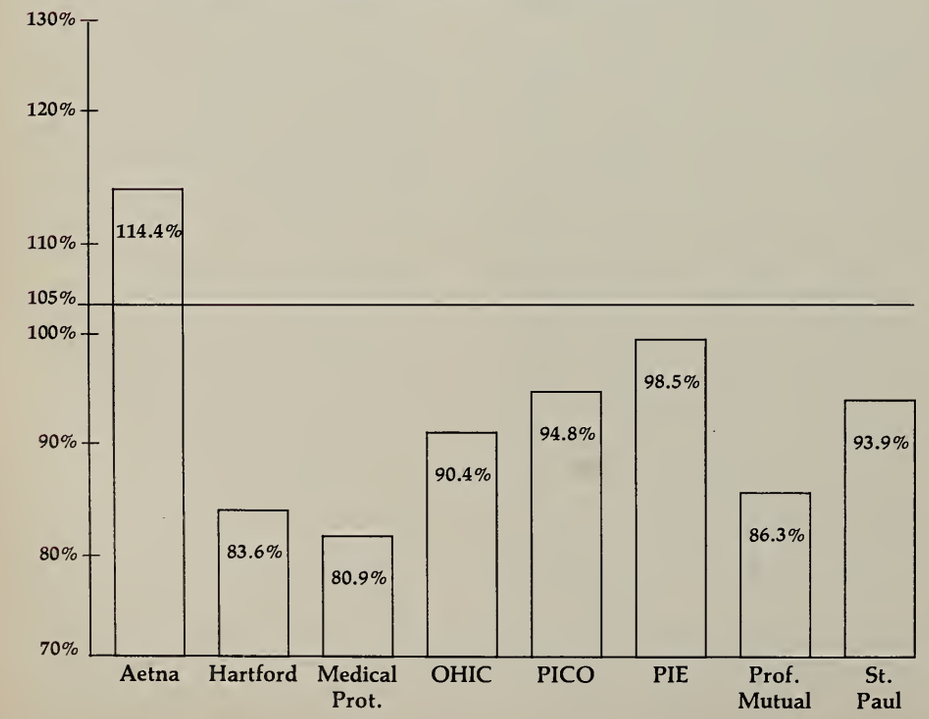
CHANGE IN SURPLUS 1981

TEST 6 — Range: upper +50%, lower −10%



LIABILITIES TO LIQUID ASSETS 1981

TEST 7 — Range: upper 105%, lower none



Test 7
Liabilities to Liquid Assets

This ratio measures a company's ability to meet the financial demands which may be placed upon it. Many insolvent companies had increases in this ratio in their final year. Deposits with ceding reinsurers are excluded from the calculation of liquid assets, while the offsetting liabilities are not so excluded. If these deposits are large, the ratio will be unduly high.

Test 8
Balance to Surplus

This ratio measures the degree of dependency upon an asset which commonly cannot be realized in the event of insolvency or liquidation. This ratio is considered by Peat Marwick to be "reasonably effective in distinguishing troubled from sound companies."

Test 9
One-Year Reserve Development to Surplus

This ratio measures the accuracy with which reserves were established one year earlier. If the current estimate of losses is greater than the reserves established for those losses a year earlier, then hindsight shows that earlier estimate to have been "deficient." If the loss were less than the established estimated reserves, then the reserves were "redundant." The "usual range" of 25% or less was picked because that value differentiated solvent companies from insolvent companies more often than other levels did.

Test 10
Two-Year Reserve Development to Surplus

This ratio is calculated similarly to Test 9 and its "usual range" is the same (25%). It tests in the same manner as Test 9; but, obviously, for a different time period.

Reinsurance was discussed earlier. As mentioned, some reinsurance treaties contain language which escalates the ceded premium in the event losses are more severe than expected. The Department of Insurance requires companies to calculate the reduction in surplus caused by such ceded premium

increases should such events occur. The potential (worst case) reductions of surplus are less than 10%, except for Professional Mutual (29%) and PIE Mutual (97%). If such severe surplus reductions should occur, one would expect a dramatic increase in premiums as a company attempts to increase surplus to adequate levels.

Rates and comparisons then were analyzed. Peat Marwick found actuarial support for the rates filed by OHIC, St. Paul, and Medical Protective. They surmise that actuarial analysis for PIE Mutual, PICO, and Professional Mutual "would likely show that present rates are inadequate."

Market availability was analyzed. Large multiline companies (i.e. Aetna, Hartford and St. Paul) probably could tolerate increased costs and decreased profits; but, also, they could leave the Ohio market (as they did 1975-76) without seriously reducing their corporate income.

The "local" companies might be less able to tolerate large increases in cost, but they are committed to Ohio market. While that commitment may preclude their leaving the Ohio market, it does not guarantee their solvency if severe losses and increased costs occur.

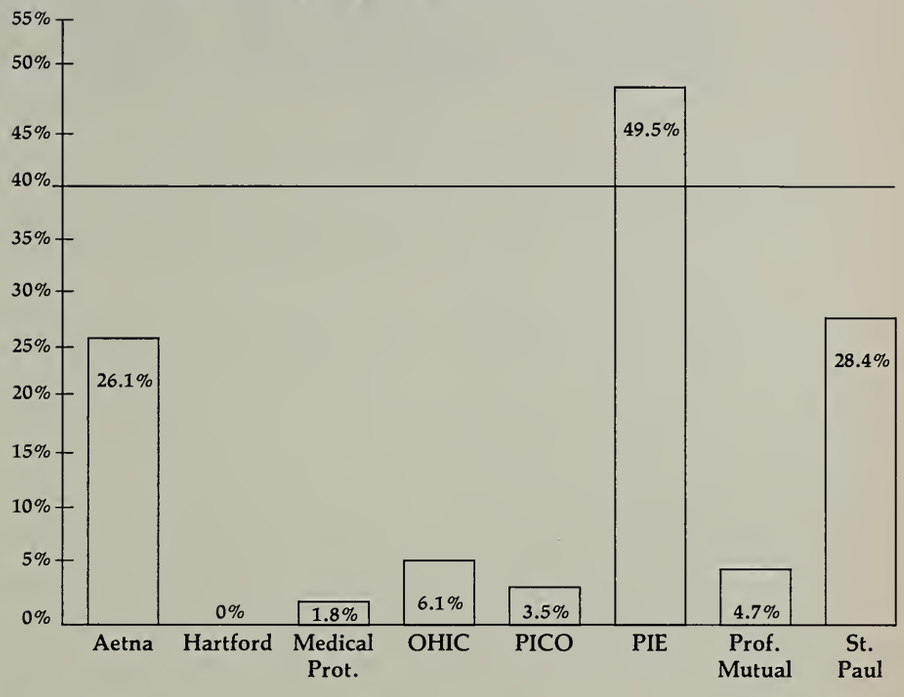
Currently, losses are increasing at a frightening rate, while earnings are declining and failing to keep pace with losses. It is Peat Marwick's opinion that there is little reason to believe that increasing losses will not continue. Unless the companies choose to go out of business, it seems inescapable that premiums must increase. It seems unlikely that gargantuan increases in premium will occur in Ohio, in the near future.

Be aware that, although the forecast is not a happy one, the news is not as bad as for those in other states. Nonetheless, I respectfully request that you not harm your humble messenger.

(The graph of Test 10 is on the next page.)

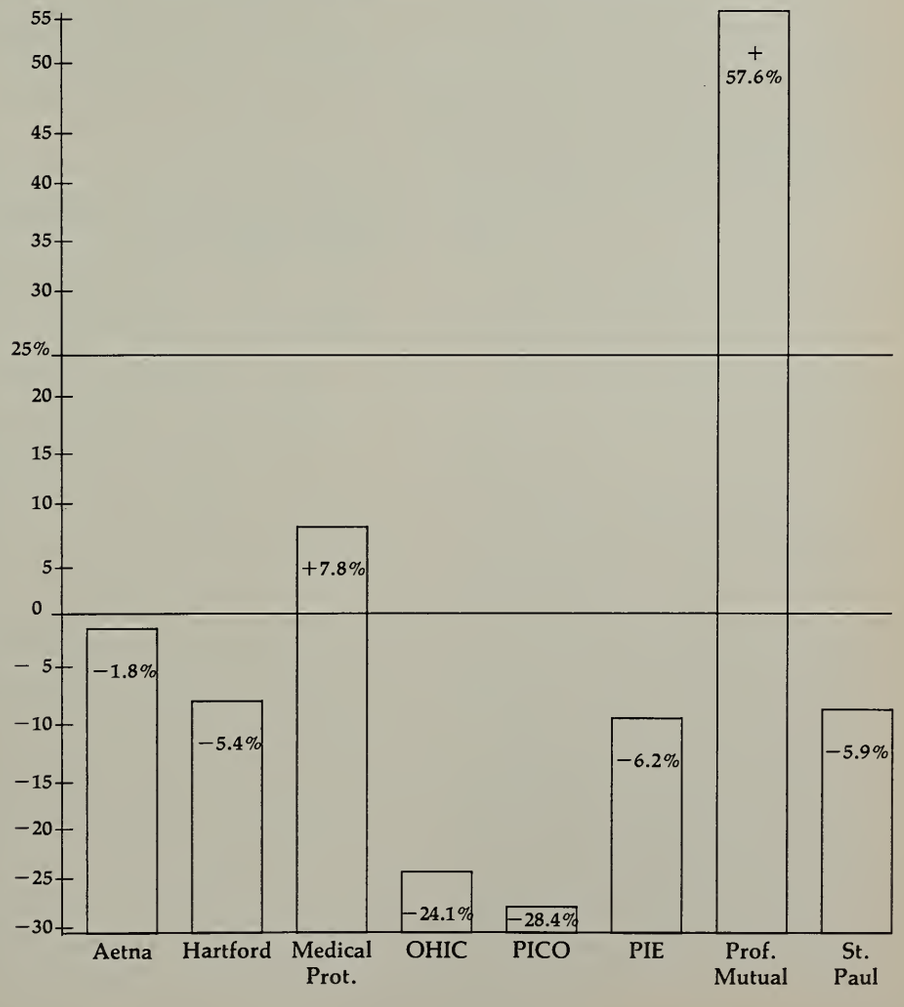
AGENT'S BALANCES TO SURPLUS 1981

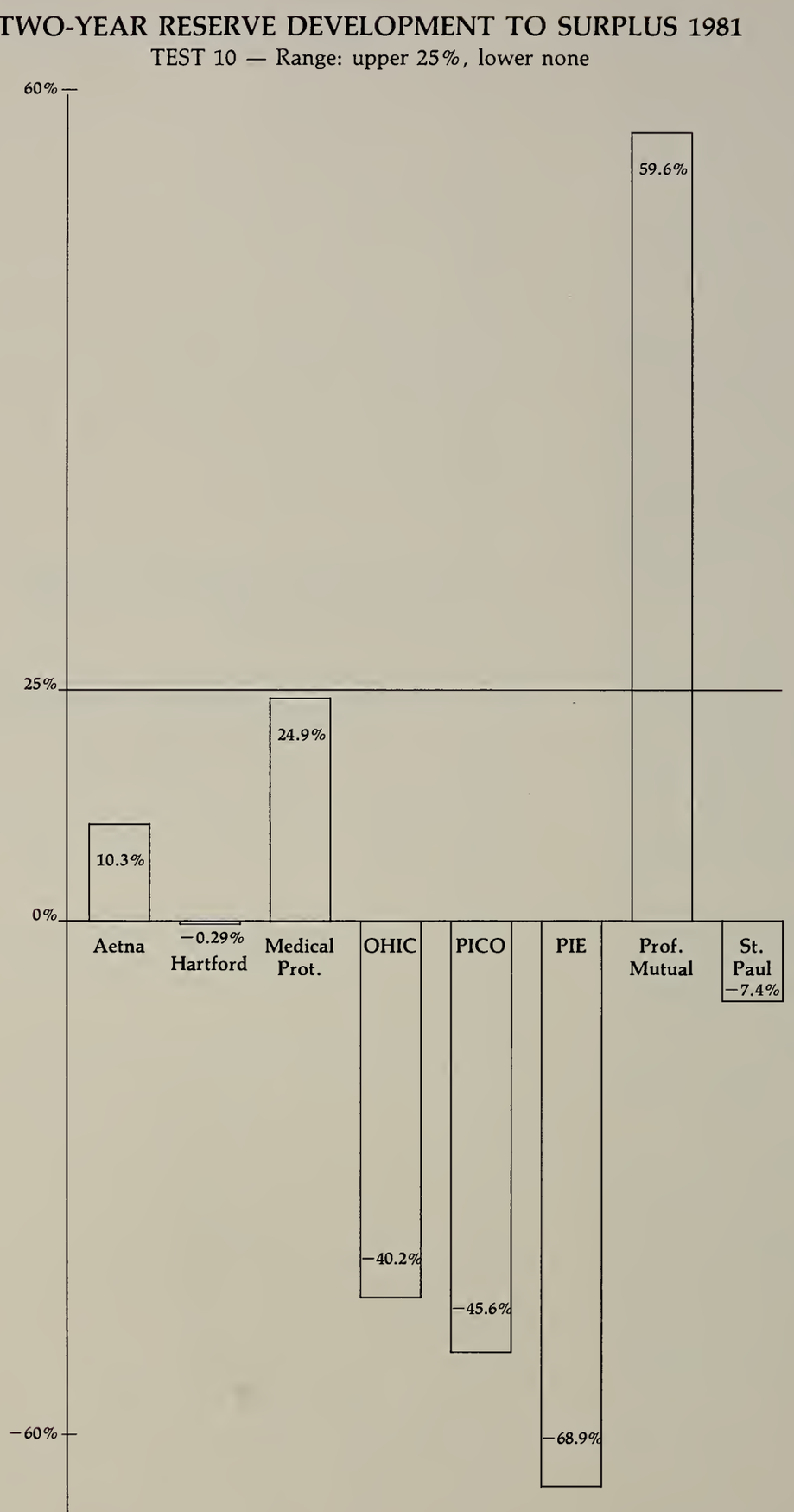
TEST 8 — Range: upper 40%, lower none



ONE YEAR RESERVE DEVELOPMENT TO SURPLUS 1981

TEST 9 — Range: upper +25%, lower none




TWO-YEAR RESERVE DEVELOPMENT TO SURPLUS 1981
TEST 10 — Range: upper 25%, lower none
60%
25%
0%
−60%
10.3%
−0.29%
24.9%
−40.2%
−45.6%
−68.9%
59.6%
−7.4%
Aetna
Hartford
Medical Prot.
OHIC
PICO
PIE
Prof. Mutual
St. Paul

Essay

A Moat of Alligators

By James David Brodell, MD

Mrs. Jones had fallen down her basement stairs and lain there a full day before her son found her. At 80 years of age, she would have been content to die there in peace. Her husband had died several months earlier and she was more than ready to join him. But, seemingly against her will, she was brought to the emergency department of our hospital.

There, I gently moved her shortened, externally rotated leg. X-Rays confirmed my suspicion of fracture. Grossly dehydrated, she lapsed in and out of awareness with each painful maneuver. I started an intravenous line, placed a foley catheter and assembled the Bucks traction. She shook her head and said, "Please let me die — I've had enough!"

Crystalline fluids dripped into her system in an amount just enough to declare an aspiration pneumonitis, and by the next morning she was laboring to breathe. I went ahead and intubated her, but with every subsequent wooshing of the machine, I felt she was wondering why I wouldn't leave her alone.

After two days of slow, clinical improvement and with the consent of her family, her hip was surgically stabilized and she was admitted to the SICU. Despite marginal vital signs and little physiologic hope, I called out her name and, surprisingly, she opened her eyes. It was obvious that she was furious with me. Not only had I proceeded with hip surgery that she did not want, but I had allowed her to survive the operation. She squinted her eyes and shook her fist at me. To have all of my efforts rejected was rather disconcerting, but I had faith she would improve and eventually thank me.

During the next week, she was extubated and progressed to chair rest, but she adamantly refused to eat or drink. She pulled out ten small, soft silastic feeding tubes. Her already depleted nutritional reserves were taking a beating so I decided to start central hyperalimentation.

With placement of the large bore needle below her clavicle, she experienced cardiac arrest. Seconds passed as I pondered what to do. Should I pump on her heart or acquiesce to her wish to die? Impulsively, I started pumping. Despite a full minute of cardiac arrest, we were still getting enough blood to the brain that she grimaced with pain from her iatrogenically fractured ribs.

Seconds passed as I pondered what to do. Should I pump on her heart, or acquiesce to her wish to die?

Ten minutes passed and her whole body, recoiling under the heavy intermittent chest massage, became lifeless. We stepped back and looked at the green, fluorescent flat line but then, suddenly, unbelievably, there it was again — normal sinus rhythm. "Damn," I thought. "She is really going to be mad at me now!"

She improved dramatically over the next two weeks, so she was transferred to a step-down unit. A cardiac monitor sent sinus blips echoing from the walls as I made one of my late night visits. For the first time in those three weeks, she looked at me; then she took my hand and gave it a gentle squeeze. "I understand what you have done," she whispered. Then, she pointed toward the blipping screen on the wall and gestured with her hands to turn it off. "No problem," I thought. "Tomorrow I'll be transferring her to the floor anyway." I flipped off the switch, and she rewarded me with a smile and another gentle squeeze of the hand. "At last," I thought, "we would become friends."

It was late. It had been a hard day. I collapsed on the creaky cot in our on-call cubicle. I must have been asleep only fifteen minutes when the phone startled me. "Doctor, It's Mrs. Jones. She's dead. Do you want a post?"

Frustration heaped upon exhaustion as the difficult three week course flashed through my mind:

"Why did she do this to me? Maybe she's not really dead. I had better go check! Why didn't I leave that damn monitor on!"

The nurse's shrill voice broke through again, "Doctor! Are you awake? On Mrs. Jones — do you want a post?"

I contemplated for only a second more. "No! Let her be! I have done enough to that poor lady!"

I was a surgical intern then. Now, six years later, I have started a practice in orthopaedics and this case still haunts my mind. Not so much because of the wrenching, emotional turmoil that is reaped, but because of the difficult moral and ethical questions which it raised and which I

A Moat of Alligators

continued

am still struggling to answer.

This woman gently passed away after a heart monitor was discontinued. She, undoubtedly, thought the machine was keeping her alive. She was kind to me, in the end, not so much in gratitude but in a bargaining posture — to coerce me into turning off the machine. When I did, then she was relieved enough to relax and die as she had wanted to from the beginning. I regret that she had to "trick" me to obtain the peace of mind she so desperately needed. I wish that I had been more considerate, thoughtful and respectful of her wishes.

We all will die and few of us will appreciate the exact timing. The fact of dying remains, despite the rapid advances in medicine, but, its timing may become more variable with each passing day. As technology progresses, there can be little doubt but that some of us may be able to choose when and where we die. For now, though, we are faced with interim problems which require thoughtful deliberation.

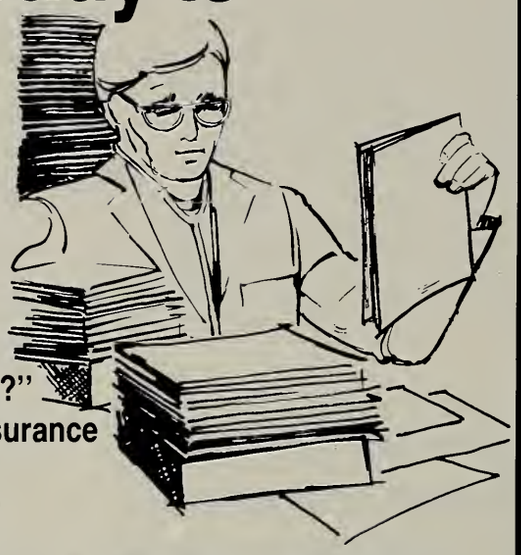
Each physician must sooner or later come out of his or her scientific castle and swim the alligator infested moat of ethics and morals. When and how much to treat will be questions that gain much more prominence in the years ahead.

The decisions will be difficult ones, no question about that. But they are perhaps best kept on a personal level — a choice made by an informed and thoughtful patient — and a doctor who has swum across that moat of alligators.

James David Brodell is an orthopedic surgeon, practicing in Warren, Ohio.

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Next month in:

THE Ohio STATE Medical Journal

CANCER
The Prospects and Progress in Ohio

Since the inception of the state-supported Cancer Consortium, there have been some new developments in the area of cancer. Next month's issue will take a look at new treatments, research, detecting cancer, handling its emotional side, and a review of the new statewide incidence reporting system now underway.

Ohio Supreme Court Reinterprets the Statute of Limitations for Medical Malpractice

By D. Brent Mulgrew, JD, and Catherine C. Costello, JD

In keeping with its clear intent to reinterpret the statute of limitations for medical malpractice in Ohio, the Supreme Court has decided another malpractice case. In Opalko v. Marymount Hospital, 9 Ohio St. 3d 63 (1984), the court was asked to construe the language of Ohio Revised Code section 2305.11 (B) as it applies to minors. That section of the statute states:

> In no event shall any medical claim . . . be brought more than four years after the act or omission constituting the alleged malpractice occurred. The limitations in this section for filing such a malpractice action . . . apply to all persons regardless of legal disability and notwithstanding section 2305.16 of the Revised Code, ***provided that a minor who has not attained his tenth birthday shall have until his fourteenth birthday in which to file an action for malpractice against a physician or hospital.*** ORC 2305.11(B)

In *Opalko*, the Ohio Supreme Court held that the statute of limitations was constitutional as it limits the filing of medical malpractice claims by minors to four years (maximum) from the time that the alleged malpractice occurred.

Last year, in another case involving a malpractice suit by a minor (*Schwan v. Riverside Methodist Hospital*, 6 Ohio St. 3d 300, 1983), the court also interpreted section 2305.11 (B). It determined in *Schwan* that the section in the statute which allowed children under the age of ten to have until their fourteenth birthday to bring a malpractice suit was unconstitutional. (set in bold italic above)

The *Opalko* opinion restricts significantly the holding in *Schwan* that the statute of limitations for minors is unconstitutional. The court states that the statute is only unconstitutional in its unequal treatment of minors above and below the age of ten.

In *Opalko*, the court makes clear that the four year bar to malpractice actions not only is constitutional, it can be applied in cases where the child was younger than ten years old at the time the alleged malpractice occurred:

> "Given the four year absolute bar contained in R.C. 2305.11 (B), we find that under the facts of the case *(Opalko)* that the plaintiff did not commence this action until nearly five and one-half years had elapsed from the date on which the cause of action accrued. As such, we find that the statute of limitations set forth in R.C. s205.11 (B) did afford plaintiff a reasonable time in which to enforce his right . . . Plaintiff's action was time-barred under the unaffected language of R.C. 2305.11 (B),"

Justices Clifford F. Brown and James P. Celebrezze dissented from the decision. The dissent, written by Justice Clifford Brown, argued that the entire section (B) of 2305.11 should be declared unconstitutional.

While the facts of the case apply specifically to a minor child, this decision may revitalize the viability of the absolute bar of medical claims. Through *Opalko*, it is arguable that if the alleged act of malpractice is not "discovered" within the four years from the event of the alleged malpractice, the claim is forever barred. The inter-relationship of this decision with the court's earlier opinion imposing the discovery rule on certain medical malpractice cases remains to be seen (see the article on *Oliver v. Kaiser Community Health Foundation*, *Ohio State Medical Journal*, p. 609, August, 1983).

The OSMA will continue to monitor cases of note and report them to you as they occur.

OHIO ATTORNEY GENERAL PUBLISHES MEMORANDUM ON PREFERRED PROVIDER ORGANIZATIONS AND THE ANTITRUST LAWS

Recently the Ohio Attorney General's office responded to a request from the Department of Insurance to review the antitrust implications of preferred provider organizations (PPOs). A ten page memorandum was prepared which reviews the general facts of preferred provider organizations but does not determine potential antitrust liability for specific fact patterns. The memorandum breaks PPOs into four groups: (1) Provider based PPOs; (2) Carrier based PPOs; (3) Third-party administrator based PPOs; and (4) Employer or union trust based PPOs. After a review of general antitrust principles that may apply to all PPOs, the Attorney General concludes "It is clear that they (PPOs) should be analyzed under the rule of reason, and that there is little apparent likelihood of unlawful price fixing. This conclusion should hold true in most cases, but the analysis can differ depending on the organizational model employed by the PPO."

The memorandum distinguishes between non-provider and provider controlled PPOs in its antitrust analysis. It states that "price fixing concerns can be minimized if the PPO negotiates the reimbursement level with providers on an individual basis." The one instance cited where price fixing could be found in a non-provider controlled PPO is when

The Physician and Ohio Law

continued

competing providers collectively set the rates at which they will be reimbursed by the PPO. This collective fee setting may be viewed as *per se* illegal.

In the case of provider controlled PPOs, the Attorney General believes that a rule of reason analysis is appropriate. "What saves this arrangement from the *per se* rule is the fact that the price setting function is ancillary to the creation of a new competitive entity, the PPO. Physicians or hospitals who combine to form a PPO do much more than fix prices, they pool their capital and undertake the risks associated with the establishment of a new method for marketing their services. The integration of marketing, claims administration, billing and other functions warrants the conclusion that the resultant price restraint is ancillary in nature . . . Thus, the setting of rates, be they in the form of discounts from hospital billed charges or discounts from physicians' usual customary and reasonable rates, or otherwise, is necessary for the successful operation of a PPO . . . For these reasons, the fee setting activity involved in a provider based PPO should be viewed under the rule of reason rather than condemned under the *per se* rule."

The Attorney General pointed out that under a rule of reason analysis, it appears that PPOs promote, rather than restrain competition. Because of this procompetitive effect, PPOs may be seen as not violating the antitrust laws, even under a rule of reason analysis.

One of the assumptions in this opinion is that the PPO does not possess undue market power. The Attorney General defines undue market power for a PPO as being instances in which the PPO's providers exceed 15%-20% of the community's providers. Beyond this, there may be the danger of reduced competition. The memorandum offers no explanation for the choice of that percentage.

The Attorney General also reviews the potential for a boycott by the PPO under the antitrust laws. He concludes that "Excluded providers remain free to pursue other available business opportunities, such as competing for the business of subscribers of traditional insurers, or by affiliating with other health plans. Thus, excluded providers are not deprived of essential trade relationships. Standing alone, then, the PPO's denial of 'preferred' status to providers does not amount to an antitrust boycott . . . This conclusion assumes that the PPO does not possess undue market power."

The memorandum concludes by stating that "PPOs are a development which should be encouraged, since they represent a market place response to the problem of rising health care costs."

Copies of the complete memorandum are available from the Ohio State Medical Association's Office of Staff Counsel.

NURSE LAWSUIT DISMISSED

The lawsuit which originated as an enforcement action by the Medical Board against a nurse and health maintenance organization for the illegal practice of medicine (see February issue of the *Ohio State Medical Journal*) has been voluntarily dismissed. As reported, the nurse had been cited for illegally practicing medicine in performing pelvic examinations, Pap smears and breast exams as part of a routine gynecologic examination without physician supervision and for prescribing birth control pills.

Prior to the dismissal, the nurse and health maintenance organization had signed a consent decree. The nurse agreed not to perform such services, and the HMO agreed not to offer the examinations unless performed by a physician.

The dismissal resulted from the inability of the parties to agree upon a substitute defendant (since the original nurse and HMO were dismissed), as well as problems with providing immunity from prosecution for witnesses testifying in the case.

The consent decree remains in effect. **OSMA**

The OSMA is registered as a 501 (c)(6) corporation with the Internal Revenue Service. To maintain such standing, the Association's activities must promote the common interest of the membership rather than provide specialized services to individuals. Consequently, this column will be devoted to general legal questions of interest to the membership. Suggestions for future columns may be sent to: OSMA Department of Legal Affairs.

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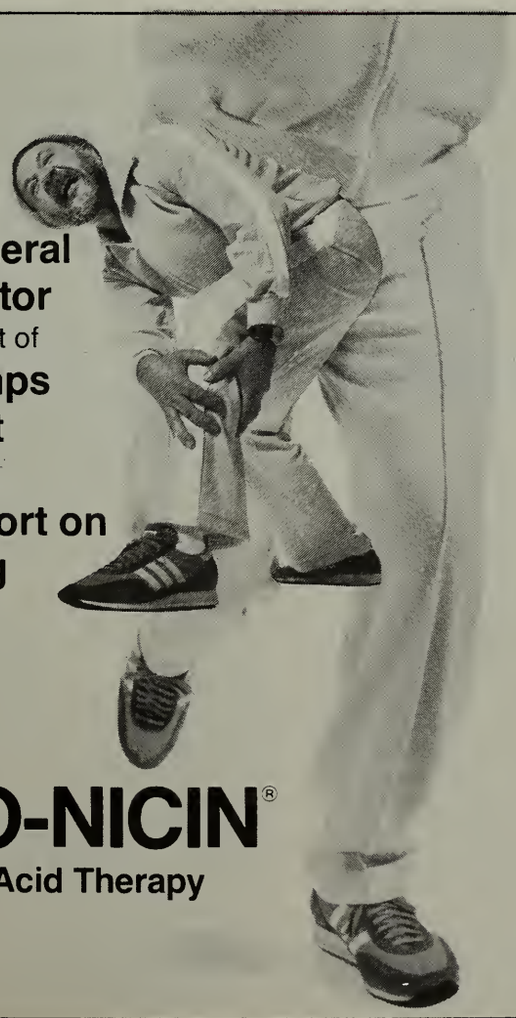
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DONALD G. ALLEN, MD, Ontario, Canada; University of Toronto, Faculty of Medicine, Toronto, Ontario, Canada, 1924; age 80; died January 5, 1984; member OSMA and AMA.

SAMUEL AMBLER, DO, Delaware; Philadelphia College of Osteopathic Medicine, Philadelphia, Pennsylvania, 1937; age 77; died January 27, 1984; member OSMA.

JOSEPH B. BIEDERMAN, MD, Cincinnati; University of Cincinnati College of Medicine, 1932; age 77; died January 19, 1984; member OSMA and AMA.

ROBERT R. BLONDIS, MD, Cleveland; Indiana University School of Medicine, Indianapolis, Indiana, 1933; age 74; died January 1, 1984; member OSMA and AMA.

VYTAUTUS P. DIGRYS, MD, Akron; Medicinische Fakultat der Reinischen Friedrich-Wilhelms-Universitai Bonn, Nordrhein-Westfalen, Germany, 1948; age 60; died January 10, 1984; member OSMA and AMA.

DAVID FRAJNDLICH, MD, Euclid; Faculte de Medecine de l'Universite de Geneva, Switzerland, 1937; age 74; died December 20, 1983; member OSMA and AMA.

THOMAS MAYL HAYES, MD, Springfield; Loyola University Stritch School of Medicine, Maywood, Illinois, 1935; age 75; died January 18, 1984; member OSMA and AMA.

WILLIAM E. HUDSON, MD, New Philadelphia; Jefferson Medical College, Philadelphia, Pennsylvania, 1930; age 78; died February 8, 1984; member OSMA and AMA.

WILLIAM A. KNAPP, MD, Zanesville; Ohio State University College of Medicine, 1937; age 74; died January 30, 1984; member OSMA and AMA.

RATKO LJUBOJA, MD, Cleveland; Medicinski Fakultet Univerziteta U Beograda, Beograd, Yugoslavia, 1952; age 65; died January 20, 1984; member OSMA and AMA.

PHILLIP J. OWENS, MD, Cincinnati; University of Cincinnati College of Medicine, 1935; age 78; died January 19, 1984; member OSMA and AMA.

FRED W. PHILLIPS, Zanesville; Johns Hopkins University School of Medicine, Baltimore, Maryland, 1931; age 78; died January 15, 1984; member OSMA and AMA.

ALBERT H. REED, MD, Cleveland; Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania, 1927; age 84; died January 27, 1984; member OSMA and AMA.

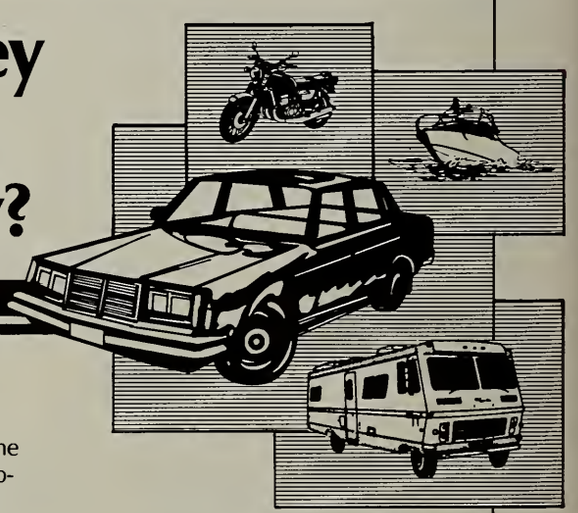
WILLIAM A. REED, Burton; Case Western Reserve University School of Medicine, 1925; age 84; died January 29, 1984; member OSMA and AMA.

LOUIS H. SCHRAF, MD, Youngstown; Deutsche Universitat Medizinishd Fakultat, Praha, Czechoslovakia, 1932; age 77; died January 14, 1984; member OSMA and AMA.

LONGIN A. SHANKOVSKY, MD, Cleveland; Akademia Medyczma, Krakow, Poland, 1935; age 74; died January 11, 1984; member OSMA and AMA.

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What To Do About The New Penicillins and Cephalosporins

By Calvin M. Kunin, MD

The beta lactam antibiotics consist of a large and diverse family of compounds all of which possess a common feature, the beta lactam ring. This ring is critical for activity; if broken by bacterial enzymes the compound becomes inactive. The original members of the family were the penicillins. These were discovered in 1928 by Fleming and then purified and shown to have remarkable effect in the treatment of bacterial infections by workers at Oxford, England headed by Chain, Florey and Abraham. The original penicillins, synthesized by the mold Penicillium, still retain a critical place in the therapy of infectious disease. Penicillins G and V are still the drugs of choice against most gram positive bacteria.

By chemical and enzymatic manipulation of the side chains of the natural penicillins, the large group of semisynthetic derivatives have been prepared. The ampicillin group (including bacampicillin and amoxicillin) have extended activity against gram-negative enteric bacteria, H. influenzae and gonococci. The "penicillinase resistant penicillins" (including methicillin, oxacillin, cloxacillin, dicloxacillin and nafcillin) are highly effective in treating staphyloccocal infections. The "antipseudomonas penicillins" (carbenicillin and ticarcillin) are highly effective against Pseudomonas, particularly when combined with aminoglycoside antibiotics and the new "broad spectrum penicillins" (azlocillin, mezlocillin and pipericillin) are even more active, at least in the test tube, against Pseudomonas, other gram-negative bacteria and the enterococcus. The penicillin family thus offers the clinician a remarkable armament for treatment or prophylaxis of infection.

In 1945, a sister group of beta lactam antibiotics, the cephalosporins, were isolated from a Cephalosporium fungus. These were modified synthetically and now are described in three general groups. These consist of the "first generation cephalosporins" (cephalothin, cephapirin, cefazolin, cephalexin, and cephradine) which have activity quite similar to penicillin and ampicillin and the "penicillinase resistant penicillins." These drugs have been shown to be of equal efficacy to the penicillins for treatment of most gram positive infections, including those due to staphylocci and for many gram-negative bacteria other than Pseudomonas. In general, they are relatively inactive against enterococci, Hemophilus, Enterobacter and many gram-negative anaerobes. Their spectrum was slightly extended with the introduction of the "second generation cephalosporins" (cephamandole and cefoxitin) to include other gram negative bacteria, particularly Hemophilus, but they still lacked activity against Pseudomonas. Cefoxitin has been found to be highly active against the anaerobic flora of the gut and remains the most active of the cephalosporins for these organisms.

During the past 5 years a new, and very large group of cephalosporins, variously known as the "third generation" or "extended spectrum" cephalosporins have been introduced and more are coming. These agents have been developed, by partial sacrifice of their gram-positive activity, to be more active against gram-negative enteric bacteria and anaerobes and some are active against Pseudomonas as well. They remain for the most part inactive against enterococci. It is extremely difficult to describe them as a group, although some of the more popular structural groups have developed into subfamilies. For example, the cefotaxime structure has been modified to produce ceftriaxone, ceftizoxime, cefmonoxime and ceftazidime. These differ mostly in pharmacologic characteristics such as clearance by the kidney and half life in the blood. Moxalactam is a unique synthetic compound that is included in the group because it was introduced about the same time as the others. Cefoperazone contains a piperazine group analagous to that found in the "extended spectrum penicillins." Its antipseudomonas activity is probably related to this side chain.

This large group of agents have many characteristics in common. All are more active against enteric bacteria than the first and second generation penicillins. Some enter the cerebrospinal fluid well (moxalactam, cefotaxime and ceftriaxone). Many have activity against Pseudomonas strains, but this is highly variable. Ceftazidime, cefsoludin and cefoperazone are the most active against Pseudomonas. They are not nephrotoxic, but adverse reactions include bleeding disorders (especially noted with large doses of moxalactam), which are either vitamin K or platelet related, a disulfiram-like effect with alcohol, drug hypersensitivity and occasional pseudomembranous colitis. All the

compounds must be given by the parenteral route and they are very expensive. As with many antibiotics they may become obsolete as new agents such as the monobactams and thienamycin (imipemide) are introduced.

The problem for the clinician is when, if ever, to use these new agents. As with most drugs, it is wise to know just a few and to know them well. I will first describe situations in which they may be potentially useful. I will then point out where these agents are clearly not needed either because other less expensive or more active agents are available, usually at lower cost, or because these agents are not effective.

CONDITIONS WHERE THE NEW BETA LACTAM ANTIBIOTICS MAY BE USEFUL

- For multi-resistant enteric gram negative bacteria including resistance to the aminoglycosides
- In patients with severe renal failure and infection due to:

  Gram negative enteric bacteria resistant to first and second generation cephalosporins or to ticarcillin or carbenicillin

  Strains of H. Influenzae resistant to other drugs

  Meningitis due to gram negative bacteria

CONDITIONS WHERE THE NEW BETA LACTAM ANTIBIOTICS ARE NO BETTER THAN CURRENTLY AVAILABLE AGENTS

- Empiric therapy in the febrile, neutropenic patient
- Prophylaxis in abdominal, pelvic or other surgery
- Treatment of infection due to obligate anaerobes
- Uncomplicated urinary tract infections, pneumonia, bronchitis, abdominal infection, sexually transmitted diseases, bone and joint infections, subacute bacteria endocarditis, staphylococcal and streptococcal skin and soft tissue infections, bacterial meningitis due to pneumococci, staphylococci, H. influenza and meningococci.

CONDITIONS IN WHICH THE NEW BETA LACTAM ANTIBIOTICS ARE

CONTRAINDICATED —
Infections caused by:
- Mycoplasma
- Chlamydia
- Rickettsiae
- Legionella
- Enterococci
- Fungi (yeasts)
- Viruses
- Acinetobacter
- Pneumocystis

RELATIVELY CONTRAINDICATED
Infections caused by:
- Staphylococci
  - aureus
  - epidermidis
- Pneumococci
- Streptococci

In addition to the relative contraindications to these agents it must be pointed out that the aminoglycoside antibiotics remain the most potent drugs for serious, life threatening gram negative bacterial infections. They can be used alone in many instances, but may be combined with using drugs other than the new beta lactam antibiotics with equal efficacy. These infections include for example, treatment of abdominal sepsis and Pseudomonas infections in the neutropenic patient. One must also consider in selecting these drugs that superinfection may occur with enterococci and that overgrowth of yeasts can occur. They exert a profound effect on the bowel flora, accounting in part for production of pseudomembranous enterocolitis. As might be expected, resistance to the new drugs is being reported more frequently. A major problem is emergence of resistance during therapy to some.

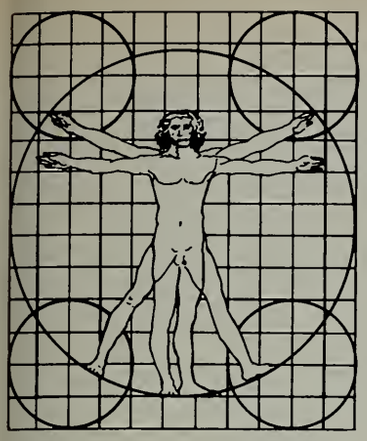
Current Assessment of the New Beta Lactam Antibiotics

I consider these agents to be "specialty drugs," to be used primarily by clinicians who have special familiarity with their indications and contraindications. Most clinical problems in infectious disease can be managed well by the older agents. This should be good news for the clinician who does not want to deny his/her patients of the latest advances in medicine. The greatest areas of potential use of these drugs are for patients who are hospitalized with critical and complicated infections. Even for these patients, an aminoglycoside antibiotic, plus an agent effective against obligate anaerobes such as clindamycin or metronidazole or cefoxitin alone, is preferred for abdominal sepsis; for the febrile, neutropenic patient an aminoglycoside antibiotic plus carbenicillin or ticarcillin is as effective as adding any of the new beta lactam compounds; for most cases of meningitis, penicillin remains the drug of choice for the pneumoncoccus and meningococcus. Chloramphenicol is still highly effective for the ampicillin resistant H. influenzae, and in complicated urinary tract infections, resistance many drugs is so common that one must be guided by antimicrobial susceptibility tests. The new agents may have special value in the long term treatment of chronic infections such as osteomyelitis due to susceptible bacteria treated for prolonged periods at home by self-administration.

Finally, it is critical to emphasize that even though these new drugs are remarkably potent against many microorganisms, there are huge holes in their antimicrobial spectrum. It is not wise to use them as substitutes for careful diagnostic evaluation and consideration of differential diagnosis. I prefer not to use them until I have a very clear indication that they are needed. They should be welcomed into the clinical armament, but I believe that it is prudent to place them under fairly strict control in the hospital. Now that there are many physicians well qualified in the practice of infectious diseases in this community, I believe that they should be consulted when one considers use of these agents. This is clearly a cost-effective practice when one considers the cost of a consultation versus that of one day of therapy. **OSMA**

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CLINICAL & SCIENTIFIC

THE STATUS OF FACULTY IN FAMILY PRACTICE TEACHING PROGRAMS IN OHIO

V. Franklin Colón, MD
Jay Gibson, PhD

In an effort to address the health care needs of Ohio, academic family medicine has been encouraged to grow, yet cuts in government spending have done injury to educational programs and development plans of the young family practice residencies. This article looks at the perceived deficit in the numbers of faculty currently teaching in family practice residency programs and projects that the gap may further widen in the near future.

IN A RECENT EFFORT to become aware of the current and projected needs for family medicine faculty in Ohio as envisioned by program directors, the authors prepared a questionnaire which was distributed to the 25 family practice residency programs in the state. Twenty-four of the programs surveyed (96%) responded to the survey. This has provided us with an opportunity to take stock of the numbers of faculty now participating in family practice teaching and to report some estimates of the needs of these programs in the next two years.

In view of the financial crisis in which Ohio now finds itself, these observations take on particular importance. If the departments queried are to be able to provide the educational, research, and health care services envisioned by their leadership, some immediate effort to provide added funding resources must be made. It is also of some importance to consider the available manpower pool in order to accomplish the developments projected. It behooves all parties in Ohio who have particular interest in the development of family medicine to seriously consider the effects of expanding the educational programs in view of a reported state wide need for primary medical care services.[1,2] The leadership of the many family practice programs, the medical colleges, the Board of Regents and the legislature need to strongly consider whether program development is feasible and/or desirable at this point in time.

From the Department of Family Medicine, College of Medicine, University of Cincinnati.
V. Franklin Colón, MD
Associate Professor and Associate Director
Jay Gibson, PhD
Associate Professor of Clinical Family Medicine and Social Psychology
Submitted September 3, 1982

Methods and Materials

In March of 1982, a one page questionnaire was prepared which asked several basic questions. The first asked that full-time faculty be categorized as either family physicians, behavioral scientists, educational specialists and physicians in other specialties. Second, the primary roles of the current faculty was requested. These roles include, physician/clinician teacher, non-physician/clinician teacher, researcher, educational specialist and administration. Third, the numbers of volunteer faculty and part-time paid faculty were requested, as well as the average number of hours spent in direct program activities. Fourth, the current shortage of faculty under the categories listed above and projected needs for faculty over the next two years were requested. Finally, the numbers of residents currently in the various programs were solicited, as well as the projected growth of the residencies over the next two years.

The questionnaires were sent and responses from several (5) programs were received within two weeks of mailing. Those that did not respond were telephoned within the next week. All surveyed programs were contacted by telephone at least once and several as many as three times. The purpose of the questionnaire was explained to the department chairman/director and/or the program administrative assistant. It is our belief that the direct communication with the departments led to the high return of questionnaires and made the survey more reliable.

Results

We have made considerable effort to minimize duplications in our faculty figures. Several programs are affiliated with university family medicine programs, and there was some occasional confusion when the university program chairmen/directors were contacted as to whether they were to include all of their affiliated programs or only their home base program. Personal communication was used to explain the study and to minimize possible overestimations of manpower needs.

Our overall findings reveal that although there have been substantial advances in acquiring adequate teaching faculties for family practice teaching programs, the chairmen/directors indicate that there are yet significant manpower deficits in several areas. When additional needs through program development and residency growth are considered, substantial faculty deficits in the near future become apparent.

There are currently 352 residents and fellows in the 24 family practice residency programs that responded (see Table 1). It is projected by program directors that there will be 451 residents and fellows in those programs in the next two to three years, an increase of 28%. These projections are based primarily on the increased number of graduates from medical colleges and



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DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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the stable number of available residency slots in other specialties. In order to keep up with the many academic needs of residency programs, the number of faculty must keep pace. There are also a number of guidelines relating to faculty to resident ratio which play a significant role in the numbers reported by program directors.[3,4]

Table 1. Residents Currently in Programs and Numbers Estimated for 1984

	Current	1984
PGY-1	118	150
PGY-2	124	148
PGY-3	105	145
Fellow/Chief Residents	5	8
	352	451

There are currently 145.5 full-time equivalent faculty in the 24 programs responding to the survey (see Table 2). Sixty percent are family physicians, 23% are behavioral science faculty, with the remainder being educational specialists (9%) and other physician specialists (8%). About half of the full-time faculty (53%) are physician clinician/teachers, about a quarter (24%) have the primary role of non-physician clinician/teacher, with the remainder working in research, educational, or administrative roles (see Table 3). Eighteen chairmen/directors (75%) also reported that they have a total of 331 volunteer faculty contributing an average of 4.3 hours per week. Twenty-two of the 24 programs (92%) report having a total of 131 part-time paid faculty working an average of 8.3 hours per week.

Table 2. Current Full-time Faculty

	N	%
Family Physicians	87.5	60%
Behavioral Scientists	33.25	23%
Educational Specialists	12.75	9%
Other Physicians	12	8%
	145.5	100%

Table 3. Primary Roles of Full-time Faculty

	N	%
Physician clinician/teacher	76.75	53%
Non-physician clinician/teacher	35	24%
Researcher	5	3%
Educational Specialist	8.75	6%
Administrator	20	14%
	145.5	100%

Program directors report that there is a current need for over sixty additional full-time equivalent faculty members (see Table 4). The majority of these positions are for family physicians (36%), followed by behavioral science faculty (18%), other physician specialists (16%), research faculty (14%), educational specialists (10%), and other non-physician faculty (6%). The estimates projected to 1984 show additional needs in all of these same areas. If the current and projected faculty deficits are to be made up, planning for funding and space provisions need to be made for approximately 100 positions (see Table 4).

Comments

Academic family medicine has been encouraged to grow in Ohio in an effort to address the health care needs of this populous state.[5] At this time of financial distress when state finances have been curtailed, a number of decisions regarding the support of higher education in general have been brought to the fore. The cuts in state as well as federal support have done injury to educational programs and development plans of family practice residencies. In order to focus on the effect of reductions on the residency programs, it is important that not only current needs be illuminated but that projections, made with the best interest of the residency programs and state, be discussed.

Table 4. Current and Future Faculty Needed

	Current	Additional by 1984	Total Needed by 1984
Family Physicians	21.5	17.5	39
Behavioral Scientists	10.75	6.0	16.75
Researchers	8.5	5.0	13.5
Educational Specialists	6.2	4.0	10.2
Other Physician Specialists	9.5	3.0	12.5
Other Non-Physician Specialists	4	4.0	8
	60.45	39.5	99.95

This survey reveals that there is a perceived deficit in the numbers of faculty currently teaching in family practice residency programs. The gap will apparently be further widened in the next two years if the 28% projected growth of residency programs comes to fruition. It is of considerable importance that the manpower pool available to provide the additional academic skills required for high quality residency programs be studied every bit as seriously as the funds needed to support proposed expansions. The additional services and space needed to support the activities of additional faculty must also be scrutinized. The tight funding situation makes it important to evaluate every expenditure in light of direct and measurable benefits to the individual programs and the state.

References

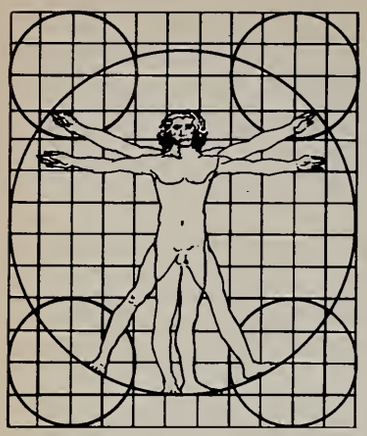
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CLINICAL & SCIENTIFIC

LASERS IN MEDICINE AND SURGERY

James S. McCaughan, Jr., MD
Carolyn Mackety, RN, BS

Since the medical use of lasers has outgrown its infancy, this introduction to their uses will help physicians answer the questions of their patients and evaluate their efficacy.

WHEN EXTERNAL ENERGY is applied in the form of electricity, high frequency light or heat, electrons in the atom being stimulated jump to higher energy levels. This is an unstable situation, the degree of instability varying with the type of atom. When the unstable electron drops back to its lower energy level, energy is given off as a photon of light thats wave length and energy depend upon the atom excited. If the atoms being stimulated are placed in a tube with a mirror at either end, the photon of light will reflect back and forth between the mirrors. As photons hit other atoms in the excited state, they drop down to a lower energy level and in turn give off a new photon of light, which will be the same wave length.

By putting enough energy into the atoms to get as many electrons as possible into the higher energy level (population inversion), more and more photons will be given off, creating a beam of light which has certain characteristics which distinguish it from ordinary light:

1) It will be *collimated* or parallel, with very little divergence

2) All of the waves from various atoms will be in phase (*coherent*)

3) It will be *monochromatic*, i.e., one color.

By placing a transparent window in one of the mirrors, part of the beam being reflected back and forth can be transmitted and this is the beam used. Thus, we have Light Amplification by the Stimulated Emission of Radiation (LASER).

All laser light has these characteristics of coherence, collimation and monochromicity; however, their properties and the effects they have will vary with the type of atom that was stimulated.

From The Laser Medical Research Foundation, Grant Hospital, Columbus, Ohio
James S. McCaughan, Jr., MD, FACS, BS Chemical Engineering Program Director Laser Research, Director, Laser Medical Research Foundation
Carolyn Mackety, RN, BS Director, Operating Room Services
Submitted November 23, 1982

A simple analogy would be bullets. They all have similar characteristics, but a .22 caliber has a different effect than a .38 caliber. Also, the effect varies with the target and how it reacts with a particular bullet or laser. The photons of light might be thought of as "bullets" of energy.

Light

Light is composed of photons (quanta) traveling in periodic waves, and the wave length is the distance between similar points on successive waves. The frequency of the wave is the number of waves that pass a point in a given time period. Wave lengths are very small, usually measured in Angstroms (A), which is 10^{-10} meters, or in nanometers (nm.), which is 10^{-9} meters. Visible light has a spectrum of approximately 390-800 nm., the various colors being associated with definite wave lengths — progressing from blue at 450 nm., green, yellow, orange and red at over 600 nm. Sunlight covers the entire spectrum, from cosmic radiation to radio waves. However, most of the energy from the sun is in the ultraviolet 200-400 nm. (approximately 5%), the visible (35%) and the infra-red (60%) range.

Lasers are now available with ultraviolet, visible and infra-red spectra and are usually named from the material that is being stimulated.

The Effects of Lasers

When light strikes any object, including cells, it may be: 1) reflected, 2) transmitted, 3) scattered, 4) absorbed, or a combination of these. Since lasers are only a special form of light, they obey all the physics and photochemical laws of light. The first law of photochemistry (Grotthus-Draper) states that light must be absorbed to provide energy for photochemical or photobiological reaction, or no reaction will occur.

What occurs when a laser beam strikes tissue, therefore, depends upon the wave length, intensity, duration of the irradiation and the type of tissue — its color, composition and size. Thus, it is possible to use the blue-green Argon laser to penetrate the eye without causing damage until it strikes the red pigment of the retina where it is absorbed and a photochemical reaction takes place.

The CO_2 laser, however, is colorless (infra-red range) and it reacts with water. Since cells are 80% water, there is an immediate photochemical reaction. The water boils and the tissue vaporizes. If it strikes the eye, severe damage will

be caused to the cornea.

The Nd-YAG is in the lower infra-red range and causes less reaction with the water and penetrates further causing more coagulation than the CO_2 laser.

The laser beam can be used by letting the beam come through the transparent window continuously (continuous mode) or it can be delivered in pulses (pulse mode). When the pulse mode is used, power built up in the laser tube (plasma tube) is let out in short bursts. This sudden release of the power gives a much higher peak power, initially striking the target. By making rapid pulses, the peak power can be delivered almost in a continuous fashion. Most operators today use the CO_2 laser in continuous mode. However, clinical work is being done with the pulsed YAG laser for special ophthalmologic indications.

The Argon Laser

Wave length of 480-514 nm. (blue-green) and has been used for two decades by ophthalmologists for treating retinal disease. Since it is absorbed by red, for the past decade it has been used and has been a great step forward in the treatment of portwine stains (hemangiomas or birth marks). This offers help to many people who cannot be helped in any other way. It is also being used for tattoos, particularly those that are colored.

The Argon laser can be transmitted through optical fibers passed through endoscopes and has been used endoscopically to treat bleeding ulcers and palliative resection of endobronchial, esophageal and gastric neoplasms.

The Nd-YAG laser, which has just recently entered the medical field, however, is supplanting the Argon laser since it is not absorbed by blood and has more power.

Research is now being done at several centers using fibers passed through blood vessels to vaporize thrombi and do valvotomies.

The Carbon-Dioxide Laser

The CO_2 laser has a wave length of 10,600 nm. and is therefore in the infra-red invisible range. Since it cannot be sent down fiberoptics, the major technical development was the design of an articulated arm using multiple mirrors to make the instrument easier to use. Subsequently, it has become the major laser in use in surgery. Focused to a fine point, it can be used to incise tissue. When used with a microscope, it is a precision instrument and the depth of damage can be controlled to less than 100 microns. Defocused, the energy is spread over a wider area and causes coagulation and vaporization.

The hemostatic effect makes it extremely valuable for surgery on patients with bleeding tendencies, hemangiomas and vascular neoplasms.

The Neodymium-Yttrium-Aluminum-Garnet Laser (Nd-YAG)

The Nd-YAG has a wave length of 1064 nm. (invisible near infra-red range). It penetrates tissue to a greater depth than the CO_2 laser and greater power can be generated than with the Argon laser. To date, the Japanese and Europeans have had the most experience with this laser. Since it can be transmitted through fibers through endoscopes, experience has been with this technique. It is being used for palliative "coring out" of obstructing bronchial cancers and esophageal cancers. Urologists are using it to resect urethral strictures and vaporize tumors.

Several U.S. centers are accumulating extensive experience with endoscopic coagulation of bleeding duodenal ulcers, gastric ulcers and esophageal varices. Enthusiasts feel it will eventually supplant the CO_2 laser for liver and large tumor resections.

Argon Tunable Dye Laser System

The Argon tunable dye laser system works on the principle of the Argon laser making a high-intensity beam which is focused on dye which is continuously circulating. This energizes the dye and causes it to lase in different wave lengths. This new beam can then be coupled with fiberoptics to be delivered through endoscopic systems or inserted directly into tumors. By varying the type of dye and using a tuning system, different desired wave lengths can be obtained. The major clinical use of this laser at the present time is in conjunction with selective photoradiation treatment of malignant tumors following the intravenous injection of a photosensitizer (hematoporphyrin derivative). This technique was developed by Dr. Thomas Dougherty at Roswell Park Memorial Institute and now is being used clinically on an investigational basis at Grant Hospital.

After the intravenous injection, the hematoporphyrin derivative disseminates to all the cells of the body. It then rapidly moves out of the normal tissue but remains longer in neoplastic tissue. After a few days, there is a differential in concentration between the tumor cells and the normal cells. When the tumor is exposed to red light, the dye absorbs the light and causes a photochemical reaction to give off singlet oxygen. This destroys the tumor cells. Since there is less photosensitizer in the normal tissue, a much less severe or no reaction occurs in this tissue. The main technical problem is getting enough light to the target area. This can be accomplished by transmitting it through fibers inserted through endoscopes or through hypodermic needles inserted directly into the tumors.

Advantages of Laser Surgery:

1. It can be focused to a very fine point and when used with a microscope is a precision tool.
2. Since the water in cells stops the CO_2 laser, it can remove tissue with a minimum amount of damage to adjacent structures, such as brain tissue.
3. Seals the lymphatics as it is used to vaporize or excise tissue.
4. By focusing the beam to a fine point, it can be used as a cutting instrument. If the beam is backed-off so the focus is above the target point, the energy per square centimeter is decreased and the CO_2 laser becomes more of a coagulating instrument.
5. Colored lasers can be used with dyes to preferentially destroy or vaporize the dye such as tattoos or pigmented tissue such as the retina.
6. The laser beam can be directed with mirrors to reach inaccessible points (pelvic endometriosis).
7. Argon and Nd-YAG lasers can be directed through endoscopes to coagulate bleeding ulcers and varices.
8. Vaporization of esophageal and endobronchial tumors.

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Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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for the varied faces of angina

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(NIFEDIPINE) *Capsules 10 mg*

* Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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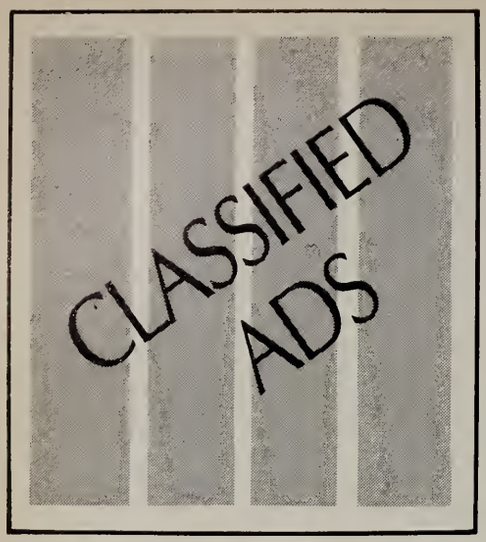
Women physicians finding more job satisfaction than male counterparts

A shorter work week and fewer pressures to advance in their careers may be among reasons why women physicians appear to be happier and more satisfied in their work than their male counterparts.

A recent survey of medical school graduates from Case Western Reserve University indicates that, as a group, the female physicians surveyed experienced higher levels of job satisfaction and felt fewer pressures to succeed than male physicians, according to a recent article in the *Chronicle of Higher Education*.

The women surveyed worked an average of 35 hours a week — as compared to 53 hours a week for the average male physician — and many had taken time off to raise children, feeling no special pressure to continue working full-time throughout their careers.

The physicians surveyed, however, were a sampling of those who had graduated between 1956 and 1965 and had attended medical school at a time when women represented only 6% of the medical school population. Today, with nearly 50% of medical school students now females, the pressure on women doctors to advance is likely to be more intense than it was 15 to 20 years ago, the article concludes.



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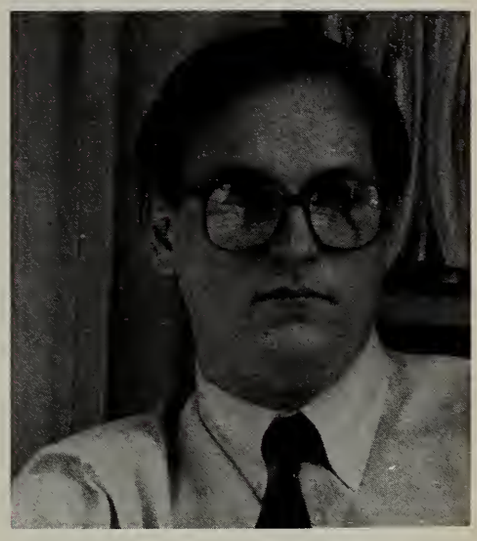
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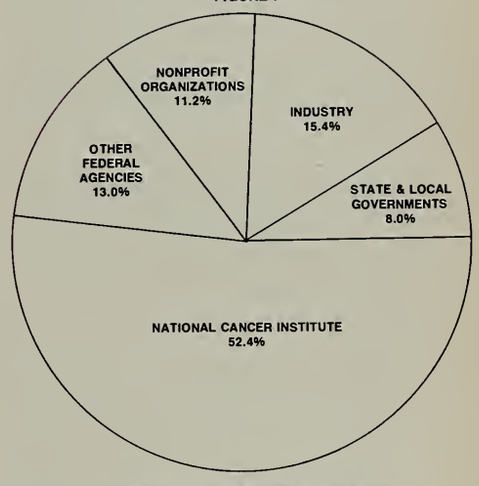
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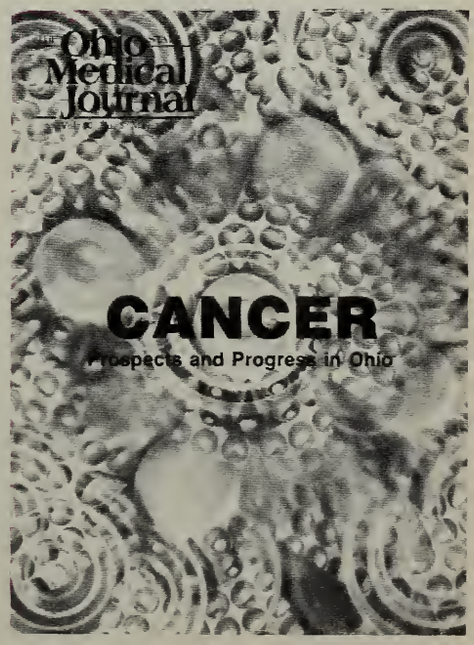
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FIGURE I



Sources of Cancer Funding, Nationwide
(Figures provided by the National Cancer Institute)

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Ohio State Medical Journal Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted *in the original* on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). *The entire text including lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACED with margins of at least one inch on all sides.*

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. *The Journal* will assume $10 of this expense and the author will be billed by *The Journal* for the remainder.

(b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.

(c). Legends for the figures should be written on separate paper.

(d). The author must affirm that he has *written releases* on all photographs in which patients can be identified.

5. **ABSTRACTS.** A *short* (100-word maximum) abstract should be included with the article. It should cover the main point so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the *order of their appearance in the text.*

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's surname and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

"2. Doe J, Roe RX: How to go about it. Ohio State MJ 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: Modern Medicine, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

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9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections and to have the manuscript retyped. Any changes, other than typographical errors, made by the Author after the manuscript is set in type will be billed to him at $2 per line.

11. **REPRINTS.** An order blank for reprints with a table covering cost will be sent with the galley proofs to the Senior Author. *The Journal* does not profit on reprint orders.

12. **EDITORIAL ASSISTANCE.** Ms. Susan Porter, *Journal* Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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S. Baird Pfahl, Jr., MD

=PRESIDENTIAL PERSPECTIVES=

THANKS FOR THE MEMORIES

By S. Baird Pfahl, Jr., MD

As my year as president of the OSMA draws to a close, I must admit it's been really great — a wonderful and exciting year for me.

Doug Ford's illness put me "in charge" early. It was unfortunate that his presidential address had to come to us via TV, and I missed having his sage wisdom and exhaustive vocabulary at my side last year. Nonetheless, as all good organizations do, we continued on.

Your state medical association has grown to record numbers of active student, intern and resident members, over 17,000 in all. We now have a student member on council and the Resident-intern section is being organized. We also hope to have a hospital staff section soon and bring more physicians and students into organized medicine. The old saying, "We should all hang together or surely we will hang separately," was never more appropriate than now. The governmental, political, third-party and "consumer" forces striving to alter the delivery of medical care, will not go away. We, the physicians of Ohio, must continue to keep as our "bottom line," what is best for the patient. We must continue to be the patient's advocate in all matters. The environment decrees that we practice "cost-effective" medicine, but it must still be good medicine provided by a knowledgable and caring physician. We must not succumb to the bottom-line of cost as the only goal. The government has said it will not worry about quality, just costs. At this time, we must continue to place the patients' welfare first and the government, the insurance industries, businesses and even our own economic pressures a distant second.

We, the physicians of Ohio, must continue to keep as our "bottom line" what is best for the patient.

Well, I'll get off the "soap box" now and back to my family, practice and community. I want to thank all of you for the "best" year of my life; it has been a pleasure serving you and the patients of Ohio. I ask you to give Burt Payne the same help and support you gave me. Burt is an exceptional person and will lead us through "whatever troubled water" lies ahead.

I also want to thank our association staff members, from Hart Page to those in the mail room, for they are the real reason why we have such an outstanding state medical association.

So as Bob Hope says, "Thanks for the memories" — and I really mean it.

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J-4044 January 1984

Cancer in Ohio: Prospects and Progress

It's time we took a good, hard look at cancer — finally.

After all, cancer is still the second leading cause of death in this country, and thousands of research dollars are being spent annually on the problem — attempting to determine a cause, or an effective cure.

Progress *has* been made, and the prospects of cancer patients are brighter now than in the past.

When we first decided to do an issue on cancer, we turned to the Chairman of our Cancer Committee, William A. Newton, MD, for help. Dr. Newton, and committee member Thomas A. Stephenson, MD, provided some invaluable insight into the subject of "Cancer in Ohio," and helped us focus our theme on "Prospects and Progress."

Members of the Cancer Consortium, too, provided their input, putting aside an afternoon to discuss contents and authors with us. Their assistance, too, was much appreciated, and of much help — not only in planning the stories, but in preparing them as well.

We hope you find this issue of the *Journal* interesting, and will learn some things you did not know. And we hope it will make you think about the work that is being done on cancer — right here in Ohio, everyday. If the prospects and progress of cancer in our state have been making strides — it's because of hundreds of men and women — like those listed below.

OSMA Cancer Committee:

William A. Newton, Jr., Chairman, Columbus
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Progress *has* been made in the area of cancer, and the prospects of cancer patients are brighter now than in the past.

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Letters to the editor

Air transport covered

To the Editor:

The Letter to the Editor on page 75 of your February issue concerning "Emergency Air Transport Not Covered" could be misleading to your readers.

Blue Cross and Blue Shield provide a number of different contract products with respect to ambulance and air transportation services. The particular contract purchased by the group through which Dr. Duffey is enrolled does not happen to cover air transportation.

Sincerely,
Neal L. McCue
Vice President, Health Affairs
Blue Shield
Columbus, Ohio

On Americanism

To the Editor:

How to rediscover the essentials of Americanism?

We must go back to the basic fundamentals. We must impart these values and basic essentials to our youth.

It is our self-imposed responsibility to do all we possibly can to protect, preserve, and pass-on the blessings of freedom to our youth, who, in turn will pass them on to other generations.

Truth is eternal; if we live by it, we prosper.

Lies are ephemeral and destructive. They create the illusion of well-being while, at the same time, destroying the fiber of a free society — and character of the individual.

Economic illusions and lies are at the heart of the destruction of a free society. Economic freedom is the foundation, cornerstone, and keystone of a free society.

The high aims, ideals, and endeavors of the Americanism Foundation, founded at Norwalk in 1979, has met with great enthusiasm. Presently, the Foundation enjoys affiliation with readers, supporters, contributors, and friends from 37 states and the District of Columbia.

Board members are leaders from all walks of life — locally and nationally.

The Foundation sponsors three annual seminars for high school youth dealing with freedom, leadership, citizenship, free enterprise, and the foundational principles of our American heritage. Approximately 50-60 high schools participate in the seminars. The students are selected by the respective administrations of the participating schools. Over 7,000 students have been addressed. 'High school assembly lectures' — is another program.

The feedback from youth; from leaders in education; from teachers; and from staff members is consistently and persistently positive. About thirteen different programs are sponsored by the Foundation — for youth; for teachers; for the community; and for radio programs.

A good offense is the best defense.

Freedom is not germaine only to the 'branch' of the private practice of medicine.

A-C-T-I-O-N truly demonstrates the depth of our convictions. Our small Huron County Medical Society has contributed $1,000 yearly to support the Americanism Foundation in its endeavors to teach our youth the truths and fundamental principles of our great American heritage.

Presently the Foundation can 'export' seminars to your high school; your community; your radio stations.

For further information concerning youth programs; programs for your community; addresses and presentations — please write or call the Americanism Foundation, Norwalk, Ohio 44857, Telephone (419) 668-8282 and (419) 668-4545.

If something ought to be done — the best way to do it is to put it in the past tense — 'It was done.'

As our President, Dr. Pfahl advises — we must RESOLVE TO GET INVOLVED. Orwell's 'presumed' 1984 can be a Re-declaration of independence and freedom.

Sincerely,
N.M. Camardese, MD
President
Americanism Foundation
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For Whose Benefit?

By William B. Saxbe, Jr., MD

A medical-school classmate recently confided to me that he was disillusioned with his colleagues because they practiced medicine, not for their patients' benefit, but for their own. Many of the major decisions in patient care were influenced by their effect on the physician's income or convenience. My own unexamined assumptions about how medicine is and should be practiced were disturbed by his simple, trenchant observation. It set me to thinking about the differing, sometimes conflicting goals of physicians, and how the coming changes in medical practice will stress the status quo.

Lest there be any doubt, I believe that the patient's benefit must be served first; but of what that benefit consists grows more complicated the longer I think about it. Furthermore, the variety and complexity of the physician's competing distractions have become more evident. Precisely *because* most of our purposes are implicit rather than explicit, they deserve scrutiny.

It is traditional for both parties to assume that the physician will act in the patient's best interests; this relationship does not exist in the marketplace in general. Physicians have always been proud of this ethical high ground; it is one of the sources of their prestige. Yet this assumption is being questioned by consumer groups and governmental agencies, which equate medical care with a commodity and its delivery with a service industry. The growth of corporate medicine has blurred the distinction between the professional and other employees. Worst of all, the overt greed of some physicians clearly demonstrates they cannot be trusted.

What benefits do patients expect to gain from a visit with a physician? First is the alleviation or cure of somatic ailments, and here we have been successful. Medicine can be justly proud of the progress of the past 200 years. Unfortunately, the scientific and technological advances which made progress possible appear to have pushed aside another traditional role of the physician: that of comforter and advocate. Yet this is the second major benefit the patient seeks from the physician. An unconscious dualism pervades modern medicine, and ills which cannot be dealt with chemically or mechanically receive short shrift. The physician of 100 years ago had little technology to give, so he gave himself. If he could not cure, he cared. The importance of this role has not been lost on such disciplines as chiropractic; armed with only bogus technology, its practitioners nevertheless sell themselves, and their patients appreciate it.

An unconscious dualism pervades modern medicine. Ills which can't be dealt with chemically or mechanically receive short shrift.

Beyond the physician's obligation to the patient's body and mind, it becomes increasingly apparent that he or she has a responsibility to the patient's (and society's) economic health. The largesse of third-party payers has obscured this duty, but as the tide of public and private assistance ebbs, patients and the general public will find themselves footing more of the bill for their care. Yet by the grace of modern technology, and with the best of intentions, it has now become possible for the physician to impoverish the patient and family with a thoroughness and speed an arsonist might envy. The wise physician of the future must be an economist as well as a scientist and humanist — though patients and families are not blameless. They may insist on a specific test or exhort the physician to "do everything possible," basing these demands on a misplaced faith in comprehensive health insurance or on the physician's ability to cure all, even when the disease is chronic or hopeless.

Where do the physician's and the patient's interests diverge? We all recognize that the physician has valid goals of his or her own: a reasonably rewarding income; reasonable working conditions and hours; and the satisfaction of doing valuable work well in the company of like-minded colleagues. These requirements may not be to the patient's immediate benefit, but the physician who does not receive them, or who cannot practice in an economically competent fashion, is soon out of business.

What we need most to worry about are those temptations which run counter to the patient's interests. I am reminded of a surgeon known for his heroic and hazardous resections who was said to "hate cancer more than he loved patients." Similarly, an internist may look on the patient's illness as a personal challenge or intellectual contest to be won at any cost, forgetting that the cost is borne by the patient, and that victory may be Pyrrhic.

However, the major temptation is money, and the fate most to be

shunned is not that of Faust or Pyrrhus but of Midas. Today it is easily possible to grow rich practicing medicine, although a projected "doctor glut" may make the future different. Technology is again the midwife of change, as a proliferation of lucrative procedures draws practitioners into a proliferation of specialties. Too little attention has been paid to the role of income in the disappearance of the family doctor, though it is obvious that a single cardiac catheterization, endoscopy, or operation may earn a physician more than a 10 hour day in the office seeing sick patients. Prestige and satisfaction now appear to accrue to the physician on the basis of income rather than knowledge or commitment.

The standard fee-for-service system has a perverse incentive for the physician to perform procedures not necessarily to the patient's benefit, since the more service, the more fee. "Unnecessary surgery" — whatever that means — is the most flagrant example, but prolonged hospital stays, repeated office visits, "confirmatory" studies, etc., also play a part.

The prepaid capitation systems of many HMOs have taken a different tack: physicians are paid per patient enrolled. The more a patient is seen, the less does the physician profit from the interchange. The temptation is for the physician to stint on diagnosis and therapy. In effect, the prepaid system makes the doctor share in the cost of medical care, fostering conservatism in the selection of tests and procedures. Ideally, the physician *should* treat prepaid and fee-for-service patients the same. While fee-for-service practice may make us inattentive to costs, and prepaid practice may make us too attentive, a mix of both may keep our attention properly tuned.

What should be done about these problems? The first step is a more enlightened selection of students for admission to medical school. Actually the ability to be a good physician must be present *before* medical school, since it will neither be taught nor learned there. Scientific information may be gained, but students will not learn in medical school or residency how to know or like people. Unfortunately, medical school faculties provide too few examples of warm, caring human beings. My own class was sensitized by a famous neurologist who humiliated a teenage patient by pulling off her wig to demonstrate that cranial radiation causes baldness.

Secondly, it needs to be emphasized and re-emphasized that diseases do not appear *in vitro*; each is surrounded by a person, and each will have physical, mental, and financial repercussions. It is easier to concentrate on the physical aspects, but that alone is insufficient. We need a widened sensitivity to the ramifications of illness: problem-solving exercises for students, clinicopathological conferences for trainees, and continuing medical education for practitioners should address and confront the threefold impact of disease.

Third, physicians should be informed about the perverse incentives which lie in wait for them; no temptation is more dangerous than the unanticipated or unrecognized one.

It needs to be emphasized and re-emphasized that diseases do not appear in vitro; each is surrounded by a person.

Fourth, I am loathe to suggest another layer of bureaucracy to monitor the present system, which rewards the performance of specific procedures, thereby promoting their performance even where inappropriate, but I do believe that this is an area where peer review offers the best hope. Peer recognition should be given for doing a good job and payment should take into consideration time and thought.

Inflated professional fees for certain procedures are an embarrassment to many physicians, who are at a loss to explain them. Cardiac surgery has the most egregious examples of this. Many of its procedures were initially lengthy, risky, and experimental; initial costs and fees were correspondingly high. But as the operations became shorter, safer, and more routine, the fees remained high. A surgeon who performs 300 cardiac procedures a year at $8,000 each earns $2,400,000! Neither that volume nor that price is unheard of, even in smaller cities. If the fee for a coronary bypass were $2,500, could we still find surgeons willing to do the operation? I think so.

Finally, prospective physicians should not expect to get rich. The present deluge of medical-school applications would certainly abate if applicants — now willing to run up large debts to become physicians — realized that wealth was not certain.

Modern medical technology magnifies our virtues and defects alike; it enables us to treat organic problems, but at high financial (and sometimes psychological) costs. Physicians have a responsibility to their patients' physical, mental, and economic health. It is the duty of the physician to serve the best interests of the whole patient.**OSMA**

William B. Saxbe, Jr., MD, practices surgery at the Oberlin Clinic, Oberlin, Ohio.

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Colleagues In The News

Edited by Ginny Strawser

WALTER DANIEL, MD, Tiffin, was recently named honorary vice-president of St. Louis University, St. Louis, Missouri, his alma mater.



University Hospital, Columbus, has been renamed the Charles Austin Doan Hall, in honor of **CHARLES AUSTIN DOAN, MD,** Columbus, who served as dean of Ohio State University College of Medicine from 1944 to 1961. Dr. Doan, an internationally known hematologist, oversaw construction of University Hospital, which was completed in 1951. The Charles Austin Doan Chair of Medicine was also established in his honor.

Officers elected to the Auglaize County Medical Society are: **THOMAS C. DOZIER, MD,** St. Marys, president; **ROBERT GILL, MD,** Minster, vice-president; and **ROBERT HERMAN, MD,** Wapakoneta, secretary.

ROBERT FUMICH, MD, Cleveland, was elected a member of the Orthopaedic Society for Sports Medicine.

SAUL GENUTH, MD, Cleveland, has been appointed to the American Diabetes Association's advisory board.

Mercy Hospital of Tiffin recently installed new officers: **SERI KAOSOL, MD,** president; **AJITKUMAR DESAI, MD,** vice-president; and **YOON T. KIM, MD,** secretary.

ROBERT LITTLEJOHN, MD, Barberton, was appointed to the board of trustees at Barberton Citizens Hospital.

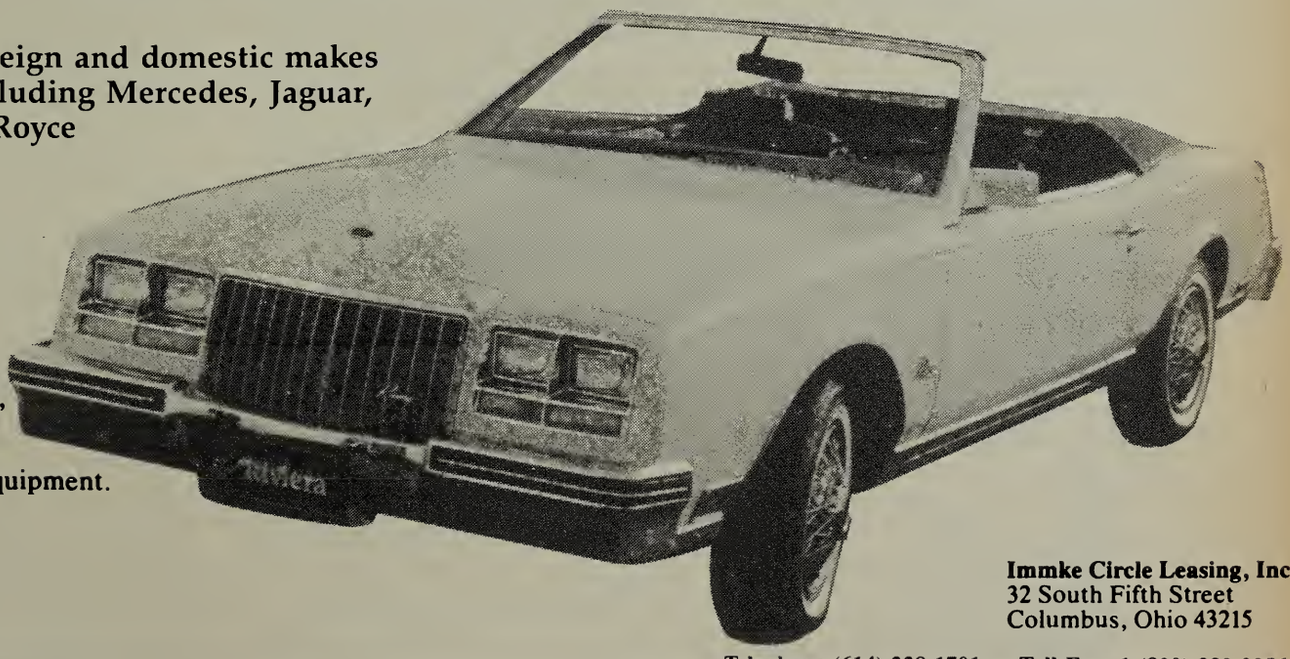
WALTER B. RUGH, MD, Mariemont, was re-elected to his second term as president of Our Lady of Mercy Hospital.

WULF H. UTIAN, MD, Cleveland, has been elected vice-president of the International College of Surgeons (ICS) United States Section, and chairman of the ICS's Division of Obstetrics and Gynecology, United States Section.

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edited by Susan Porter



Husband/wife teams have pros/cons

The increasing number of women in medical schools is prompting a trend towards more husband/wife physician teams, points out a recent article in *Pulse*, a monthly publication of St. Alexis Hospital in Cleveland. The practice has both its advantages and disadvantages, according to the story which focuses on three physician couples on the hospital's medical staff who also share offices outside the hospital.

Among the good points: "a special understanding of each other's problems and hectic schedule and the sharing of each other's patients in many cases."

According to one physician interviewed, "Because my wife has to keep long hours as a doctor, if I wasn't a doctor, too, I would never see her." Said another, "I don't have to put in as many hours as a doctor working alone. There is a division of labor."

Another benefit listed by one physician was the cooperative — rather than competitive — nature of the husband/wife team; one member can refer patients to the other, without fear of permanently losing business.

The main disadvantage of the husband/wife practice listed was its impact on children. Too much "shop talk" over the dinner table, along with a general lack of time to spend with the children were cited by all couples interviewed. However, those with grown children noted their offspring had grown up more independently "than the other children on the block." One couple with young children related they have helped ease the situation by spending most of their free time with the children.

Ovum transfer raises questions

The ovum transfer procedure, which involves removal of a fertilized egg from a donor woman and implantation in a recipient "mother," may be illegal in Minnesota and of questionable legal status in several other states, according to a recent article in the *Journal of the American Medical Association*.

The procedure, which recently resulted in the world's first delivery of an infant so conceived and carried, raises questions in three discrete areas of law, according to the article, written by a professor at the University of California School of Law.



The first concerns governmental regulations regarding fetal research. While the procedure appears to clear federal rules which define a fetus as "the product of conception from the time of implantation," some states, such as Minnesota, protect any "human conceptus" from the point of fertilization on.

Additionally, some state laws prohibiting the sale of children have been extended to include surrogate motherhood for pay; these might be further extended to include monies paid ovum donors, although most state laws are aimed at protecting fully-developed infants, the article says.

A third area of difficulty revolves around state definitions of "rights of participants," including paternity and maternity of the infant. Because existing laws were not drafted with ovum transfer in mind, questions concerning who is the legal father and who is the legal mother of the ovum transfer child have yet to be answered, although artificial insemination donor statutes may set the precedent favoring social reality instead of biological reality, the article says.

Prognosis improving for childhood cancers

Childhood deaths from Hodgkin's disease, kidney cancer, leukemia, bone sarcoma and most other childhood cancers have declined dramatically since 1950, according to a 30-year review of death certificate diagnoses issued by the National Cancer Institute. The report, published in a recent issue of the *Journal of the American Medical Association*, says the decline in mortality is due almost entirely to improved therapy.

During the period 1965-1979, childhood deaths due to Hodgkin's disease fell 80% compared to the number expected at 1950 rates, while the decline was 68% for kidney cancer, 50% for leukemia and bone sarcoma, 32% for non-Hodgkin's lymphoma and 31% for all other childhood cancers.

Data from 1980 show that mortality rates from Hodgkin's disease, bone sarcoma, kidney cancers and "other" cancers seem to have reached a plateau, but deaths from leukemia and non-Hodgkin's lymphoma are still declining.

Further gains are expected as new methods are developed for treating individual tumors, according to the article, which adds more basic research in molecular biology and pharmacology is needed to provide clinicians with further ideas for more effective cancer treatments.



Teleconference centers on health care programs

Columbus and Cincinnati were among 25 cities across the country to participate in a national teleconference on the value of employee health care programs. Sponsored by the Health Insurance Association of America (HIAA), the closed-circuit video teleconference on health care was an industry first, according to HIAA, which regarded the event as "a major national initiative to advance worker wellness in America."

The purpose of the hour-long forum, titled "Wellness and the Bottom Line," was to discuss how business and industry can improve employee health care and at the same time increase worker productivity and slow the increase in health care costs.

The electronic conference originated at the Department of Health and Human Services (HHS) in Washington. President Ronald Reagan opened the telecast, followed by a national panel discussion led by HHS secretary Margaret Heckler.

The discussion was followed by a two-way audio question-and-answer segment between the panelists and teleconference attendees in the 25 cities. Martin Keller, MD, professor and chairman of the department of Preventive Medicine at the Ohio State University, was among panelists who led discussions in Columbus.



From the OSMA bookshelf

The Official MD Handbook. By Anne Eva Ricks, MD, NAL/Plume Books, $4.95.

Billed as "The Life of a Doctor from Medical School to Malpractice Insurance," this book, written by a University of Cincinnati medical school graduate, takes a humorous look at the trials and tribulations of being a doctor. Chapters include: "How to Get Into Medical School; or, Don't Believe Them When They Say, 'There Is No Right Answer to This Question,' " "Choosing a Specialty"; and "The Doctor's Social Life and Other Overrated Phenomena." The book is in its second printing, and Dr. Ricks, currently finishing an internship in Boston where she will open a private practice, is already at work on her second book.

Drug effective against skin tumors

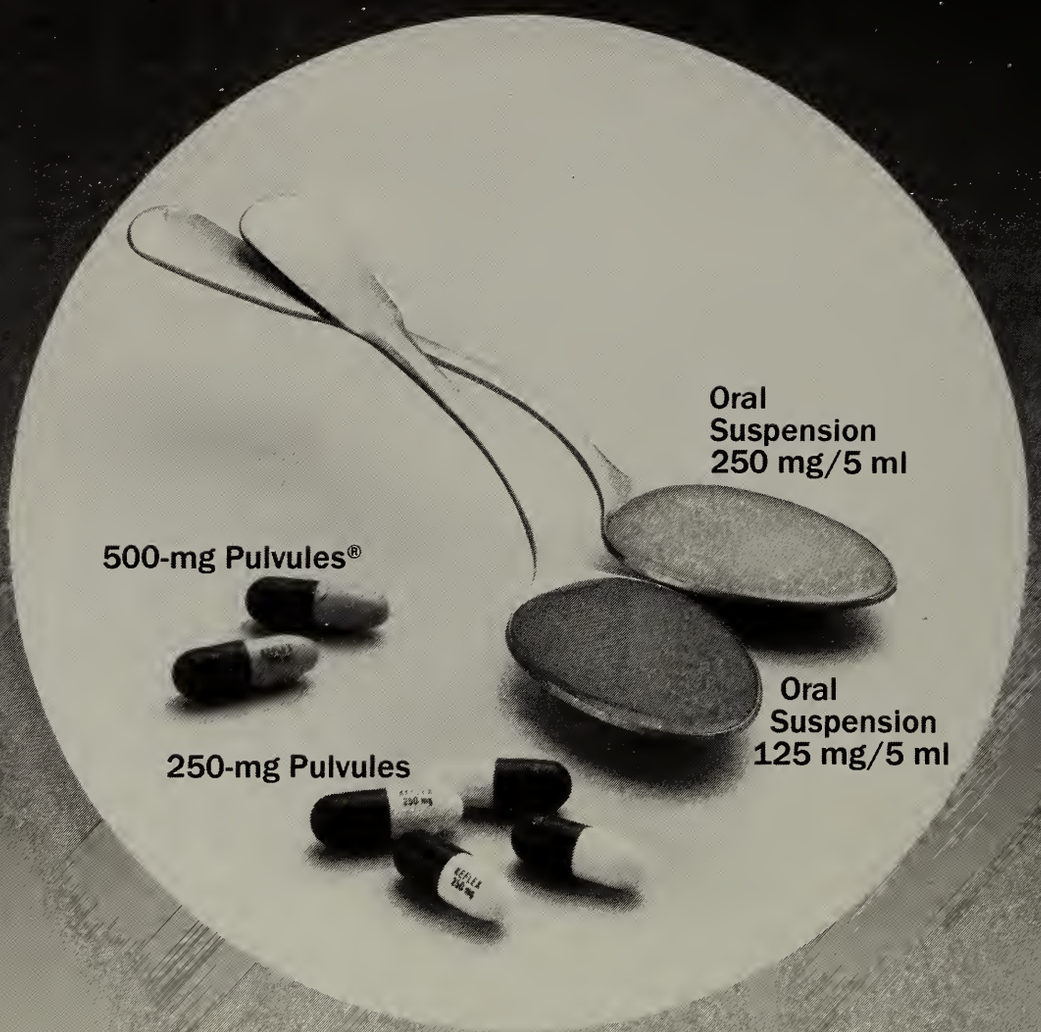
Acyclovir, an anti-viral drug commonly used to control herpes simplex virus, has been found successful in clearing mycosis fungoides, a rare malignant lymphoma that begins in the skin, frequently involves internal organs and usually is fatal.

According to a recent article in the *Journal of the American Medical Association*, the drug was used on a 58-year-old woman suffering from mycosis fungoides skin tumors. When the standard anti-cancer drugs administered were followed by herpes eruptions, acyclovir was administered intravenously.

The therapy resulted not only in a clearing of the suspected herpes lesions, but also in a regression of the potentially fatal skin tumors, according to the report. When the tumors reappeared after eight weeks, a second course of acyclovir therapy again resulted in regression.

The serendipitious discovery is important because it supports the hypothesis that oncogenic viruses are involved in the development of certain cancers. The group of viruses called retroviruses has been implicated in the etiology of T-cell lymphomas, the group to which mycosis fungoides belongs, according to the report.

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OSMA Committee on Cancer

Making Advances, Meeting the Challenges

By William J. Newton, MD

The OSMA Committee on Cancer is comprised of physicians from a wide variety of specialties and practice settings who are concerned with the problem of cancer.

The Committee serves as a sounding board and an advisory body to the OSMA Council. It meets as needed to address specific issues in order for physicians to be properly represented within OSMA and also within the legislative and other arenas.

During the past four years the Committee has been concerned with several specific issues, including the following:

- Support of the hospice concept for the terminally ill
- Support of smoking and health projects — including a statewide conference on "Smoking and the Workplace"
- Efforts at the grassroots level through county medical societies to launch the Ohio Cancer Information Service
- Support of the American College of Surgeons efforts to develop approved cancer programs in hospitals
- Publication of both scientific and lay-oriented material on prevention and treatment of breast cancer
- Support of a cancer incidence reporting system for Ohio

As Chairman it has been my privilege to represent the Committee and OSMA on the Consortium for Cancer Control in Ohio (CCCO). CCCO represents a variety of professionals and professional organizations as well as agencies concerned with health issues, and the lay public.

Included in the CCCO are the Ohio Department of Health; Ohio Division, American Cancer Society; American Lung Association of Ohio; the Leukemia Society of America; and the American College of Surgeons, to name a few.

It is extremely important that we make the individual physician aware of the effort to coordinate the talent and resources throughout Ohio ...

CCCO was challenged to develop a meaningful, viable mechanism to pool the resources of all individuals and organizations concerned with cancer — and to address the specific problems of the cancer continuum, from prevention through follow-up treatment.

The organization has met with statewide and national acclaim. Its progress to date indicates that this teamwork effort helps to define and resolve tough problems. It is extremely important that we make the individual physician aware of this effort to coordinate the talent and resources throughout Ohio in order to help in his/her day-to-day work with cancer patients.

There are special areas of emphasis within the CCCO at present. One is the development of a mechanism to document the incidence of cancer by specific types, by geographic area. This will provide vital data so that specific entities (cities, villages, counties, etc.) can better understand their problems and needs. In other words, we can identify "hot spots" which could stimulate the search for causes of the increased incidence. One of the side benefits would be reassurance in regard to the safety of living in Ohio.

Some communities in the past have been accused of having more cancer cases than the "average." The validity of these accusations is highly suspect. Until the incidence is determined by an effective survey, this type of speculation should not be given significant attention.

Another major program being supported by state funding through the CCCO is the Ohio Cancer Information Service (OCIS). This is an outgrowth of the sophisticated information program of the National Cancer Institute. Through computerized efforts, up-to-date regional cancer information specific to

continued on page 386

Early Detection of Cancer in Office Practice

By Roland T. Skeel, MD

Of the 440,000 people who died of cancer in the United States in 1983, the American Cancer Society estimates that 145,000 or more than 30% might have been saved by earlier diagnosis and prompt treatment.[1] In Ohio alone, that means that early detection and treatment might save as many as 6,800 lives yearly.

All cancers are not equally suitable for early detection, and screening or detection programs have their own set of costs and other risks that must be considered. All physicians should therefore understand the presumptions and principles that underlie cancer detection, the value in selecting the appropriate population for evaluation, and the potential costs and risks to early cancer detection programs, as well as the possible benefits that might occur. Guidelines appropriate to an individual physician's practice can then be formulated, by which maximum benefit can be derived.

Principles, Potential, and Problems In Early Detection

Cancer Screening is the "presumptive identification of unrecognized disease or defect by the application of tests, examination, or other procedures that can be applied rapidly."[2] It is important to note that the "presumptive identification is different from diagnosis, and further steps are nearly always necessary to establish the diagnosis of cancer with certainty. It also bears mentioning that *screening* programs apply only to those who have previously unrecognized disease. This implies that a person would have a check-up or evaluation in the absence of any symptoms. Early *detection* is somewhat broader, in that it includes both screening and earlier diagnosis in those who have symptoms. Success in earlier diagnosis is dependent both upon patient and physician behavior in appropriately pursuing the cause of symptoms that may presage cancer.

Screening and early detection programs in cancer are based upon the presumption that early diagnosis of cancer or a pre-cancerous lesion will result in substantially fewer deaths from that cancer. Whether or not this will be true depends not only upon the availability of tests or procedures to find early lesions but upon a stepwise progression of cancer from localized to regional to metastatic disease. The benefit of early diagnosis is also based upon the assumption that there is no substantial regression of pre-cancerous lesions, and that the screening process and subsequent evaluation will not result in greater mortality from the cancer or other disease or complication.[3]

Who will benefit from the screening or tests used in early diagnosis is often not appreciated nor communicated to the person undergoing screening tests. If a screening test is worthwhile, the health of the community and of the individual whose cancer was found in a more curable stage can be expected to be better; this does not necessarily mean that the health of each individual screened will be improved. At a minimum, there should be an overall benefit to the community at a minimum risk to individuals. Individuals at potential disadvantage from screening include:

- those who would have been (as easily) cured if the disease had presented normally;
- those who die despite screening and earlier diagnosis;
- false positives who must go through further extensive (and expensive) testing;
- false negatives who are falsely reassured.

Thus for any screening test, the possible disadvantages must be considered along with the possible advantages.

The principles that should underlie screening programs were delineated in an International Workshop on Screening in Cancer in 1978:[4]

- The disease should be an important health problem;
- The natural history of the condition should be known;
- The disease identified by screening should be treatable;
- There should be evidence of the reduction in mortality expected by treating lesions detected by

screening.

While cancer as a whole is an important health problem, not all cancers are major problems to the population as a whole. Discretion must therefore be used in choosing which cancer to screen for. The natural history of most cancers, though variable, is well known, but the treatability varies greatly, and the evidence that reduction in mortality may be reasonably expected by treating lesions detected by screening is scanty, except for carcinoma of the breast. It is also important that the ability of the test to detect those with disease (the sensitivity) and its ability to correctly identify those free of disease (specificity) be known. From these parameters and a knowledge of the prevalence of disease, one can then determine the predictive value of a positive test (percentage of those who test positive who have disease). For a disease with a low prevalence, even with a high sensitivity and specificity, the large majority of those who test positive will turn out to be free of disease. The higher the prevalence, the greater the likelihood that a positive test will indicate the presence of disease, that is, that a positive test will have a high predictive value.

Even if the principles of setting up a screening or in-office cancer detection program are adhered to, many patients may not avail themselves of the opportunity to participate. The psychological reasons behind this are varied, ranging from fear of losing an important part of their body, to the ostrich phenomenon: "If I don't look, maybe I'll be safe."

Recommendations For Early Detection of Cancer.

Based upon the previous discussion, routine, scheduled screening for several kinds of cancer can be recommended to family practitioners and other primary care physicians:

Breast Cancer. Early detection of cancer is of established value in carcinoma of the breast in which deaths may be reduced by 30% in those over the age of 50, and 23% or more overall.[5] It is currently recommended by the American Cancer Society[6,7] (ACS) that women do the following:

Age 20 and up — breast self-exam monthly;
Age 20-40 — breast physical exam every three years;
Age 35-40 — baseline mammography;
Age 40-50 — yearly physical exam, mammography every 1-2 years;
Age 50 and up — yearly physical exam, yearly mammography.

Each of the components — self-exam, exam by a professional, and mammography — appear to be important.[8] These recommendations are reasonable, though it must be noted that data to support reduced deaths from the early detection programs are only available above the age of 50.

Colon Cancer. The value of screening for occult blood in the stool is as yet uncertain, but it is possible that deaths from colon cancer might be reduced by 50% or more. Digital rectal exams yearly over age 40 and testing the stool for occult blood yearly over age 50 are currently recommended by the ACS, and are good early detection tests. Meticulous dietary preparation (meat free, high fiber) and avoidance of vitamin C, aspirin, or iron[9] are critical to avoid false positive or negative occult blood tests. Sigmoidoscopic exam every three to five years after two negative exams one year apart after age 50 is also recommended, but has a low patient acceptability, due to discomfort that may accompany the procedure and high cost, two factors that prevent its wide use.

Cervical, Ovarian and Endometrial Cancer. The evidence that early detection of cervical cancer by the Pap test results in fewer deaths is indirect, but is generally accepted by gynecologists, epidemiologists, and by women. The optimal frequency is not known, but owing to the long natural history of carcinoma in situ, which in the majority of cases precedes invasive carcinoma of the cervix, yearly Pap tests are not recommended except in high risk women (early age at first intercourse, multiple sex partners). Based upon consideration of benefits, risks, and practicality, Pap tests are recommended for normal risk women, age 20 to 65, every three years, after two negative exams one year apart. A pelvic exam should be done at the time of each Pap test. Women over 40 should have a yearly pelvic exam to look for evidence of ovarian carcinoma and to have a digital rectal exam. Women at high risk for endometrial cancer (history of estrogen use, abnormal uterine bleeding, infertility, obesity, failure of ovulation) should have endometrial tissue sampling at menopause, or at the time of abnormal bleeding.

Lung Cancer. There is no sound evidence to support either routine sputum cytology or chest x-ray to detect lung cancer. Several studies are on-going to see whether very intensive screening in high risk persons is of value, but to date, attempts at early detection have not resulted in a survival benefit for those screened.

Other Cancers. General physical exam can detect several kinds of cancer in which the prognosis is better for early than for late disease:

— thyroid

Who will benefit from the screening or tests used in early diagnosis is often not appreciated nor communicated to the person undergoing screening tests.

— testes
— prostate
— head and neck (oral)
— skin
— lymphoma.

While the benefit of health counseling and a cancer check-up has not been shown for these cancers, they are recommended every three years for men and women age 20-40, and yearly thereafter.

Establishing the Diagnosis. Once a presumptive identification of a problem has been made by a screening test, further steps are necessary to establish the diagnosis. This may be through further physical exam, laboratory or radiologic study, or biopsy. As a rule, this is best carried out by the primary physician, together with an appropriate specialist such as a surgeon who may be required to perform a biopsy. By performing careful follow-up on patients with a positive screening test, a determination can be made whether or not a cancer or pre-cancer exists. If none does, the patient can return at an appropriate interval for continuing routine screening.

If cancer is present, the correct management will depend upon the type of cancer, the extent of the disease, the expertise of the local physicians, and the facilities available. In most circumstances, patients will benefit from a multi-disciplinary approach to care from the time of diagnosis on. This allows the primary physician to give the patient the very best advice about appropriate steps in pre-treatment evaluation, treatment, and rehabilitation.

Cancer screening and early detection is not just the job of cancer screening clinics and hospitals. It is the responsibility of each physician, together with his/her patients. If cancer screening, as recommended, is carried out in any office practice on a regular basis, together with risk reduction education, deaths due to cancer could drop by 50%. It is a challenge that deserves our serious consideration. **OSMA**

Even if the principles of setting up a screening or in-office cancer detection program are adhered to, many patients may not avail themselves of the opportunity to participate.

Roland T. Skeel, MD, is professor of medicine; chief hematology/oncology director; MCO Cancer Program, Medical College of Ohio, Toledo.

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Why Ohio Hasn't Had a Statewide Cancer Incidence Reporting System

. . . and What It Is Doing About It Now . . .

By Karen S. Edwards

It doesn't make sense.

Cancer is one of the leading causes of death in the country. Here in Ohio, approximately 21,000 die of cancer each year, and over 40,000 new cases are diagnosed. During 1980, one cancer death occurred every 26 minutes, costing the people of Ohio over $1.5 billion a year in direct and indirect costs.

Yet, up until last year, Ohio had no organized statewide incidence reporting mechanism — no means of determining the impact of the cancer problem in Ohio, or for developing baseline information in order to measure the success or failure of cancer control programs and activities.

"That's not really unusual," says John Wilson, PhD, an epidemiologist who has recently been hired by Ohio's Cancer Consortium to establish an incidence-reporting system for the state.

"I'm only aware of 15 or so states — most of them on the east coast — where such statewide reporting is currently done."

Why? Why are such systems, which seem so important that they are often *presumed* to be already in existence, so slow to develop?

"For one thing, state government must provide the necessary funding to get any reporting system off the ground," says Wilson.

Ohio is fortunate in that, last year, its General Assembly put its money where its concerns were and allocated $995,000 to the Cancer Consortium which, in turn, channeled part of those funds toward establishing a statewide cancer incidence reporting system in Ohio.

The Consortium ranked the need for such a system as second only to the need to reduce the death-rate from cancer in the state.

In an issue of the Cancer Consortium's newsletter "Overview," Chairman William A. Newton, Jr., MD, wrote:



John Wilson, PhD

"When you're involving just the pathologists, you're only counting those patients who have had biopsies at the hospital. Up to 20% of the cancer patients seen by the hospital may be lost to the reporting system simply because they are not operated on."

"One of the highest priorities of our proposal to the legislature was the implementation of a system to determine as closely as possible the incidence of cancer in the State of Ohio. The incidence system has been given the endorsement of many leading organizations in the state in an almost unanimous fashion. Clearly, this is one program the state deems important. This information, the incidence of cancer by geographic area, will serve as a building block, the corner stone, if you will, for many projects, in planning, in teaching, and for carrying out much needed studies."

But even with funding and unanimous statewide support, launching a statewide voluntary cancer incidence reporting system is not easy — a second reason why such systems are not more prevalent.

Finding an efficient, yet accurate way to collect data is, at best, time-consuming — a trial and error method that bears more resemblance to launching a rocketship than a hot air balloon. After all, if lift-off occurs, chances are it won't be immediate. It will come in stages — and that's exactly how Ohio's Consortium personnel are proceeding with a statewide reporting system.

STAGE I: Deciding on the System

The Cancer Data Management Committee, which is an advisory committee in charge of the reporting project, was anxious to get the reporting project off the ground as soon as possible. But how best to do it?

"The committee opted to test the feasibility of a voluntary, pathology-based system," says Wilson, "because they saw it as the least expensive, and least invasive way to develop a data-collecting system."

The decision to use pathology reports as the prime documents to indicate the incidence of a given cancer had immediate advantages. After all, the reports were already being done, so all the Consortium needed to do was to develop some method to standardize them.

But hospital/pathology cooperation, as well as participation, was vital, so after reaching their decision as to how best to collect data, the committee quickly sought — and received — endorsements from such health professional groups as the Ohio Hospital Association, the Ohio Pathologists Association, the Ohio Osteopathic Association, and the Ohio State Medical Association.

Other groups, however, expressed concerns.

"Some thought there would be a duplication of efforts," Wilson says, explaining that "a number of Ohio hospitals have tumor registeries already in existence, and these critics felt our system would be duplicating the registeries' efforts."

Wilson agrees the point is well taken. Hospital tumor registeries, as well as the larger central registeries (such as Cancer Data System in Cleveland, which collects tumor data from multiple hospitals in the area) do report on patients diagnosed and or treated for cancer within their hospitals.

"But not all hospitals have tumor registeries," says Wilson, "So we would miss a lot of patients if we were to depend on them exclusively. Some method of collecting data from institutions without tumor registeries must be developed."

In November last year, a pilot project to test the feasibility of a pathology-based reporting system was begun in both Franklin and Allen counties.

STAGE II: Testing the System

"The two counties were chosen to provide a representative look at how the system would function in a rural, as well as a larger, cosmopolitan county," Wilson says.

In a letter to hospital CEO's seeking participation and cooperation in each of the two counties, Wilson wrote:

"We are requesting that copies of pathology reports for all reportable cancer cases newly diagnosed after November 1, 1983 be sent to the Cancer Control Consortium of Ohio (CCCO) Central Office for processing on a monthly basis over the next six month period. This would require that the pathologist identify an individual

who would be responsible for supplementing the pathology reports with medical records/tumor registry information, and serve as a contact person with the CCCO central office.

Data analysis will be descriptive in nature with the identification of patients and reporting institutions remaining confidential at all times."

Cooperation was successfully obtained from all the hospital pathologists in Franklin and Allen counties, and, according to Wilson, the system has been operating smoothly so far.

Once the pathology reports are received by the Central Office, they are given an identification number, the information is verified and the whole is coded and matched to eliminate any duplicate cases. Then the report is sent to the Ohio Department of Health to be processed.

The resulting report, which is placed in files, costs about $15 in total — including personnel costs.

The cost of the program will not be the single determining factor in assessing its value, however.

"We hope to have a report ready in August which will evaluate a pathology based system," Wilson says.

The pathology-based reporting system is not foolproof, however, and already disadvantages in this type of system are beginning to appear.

"When you're involving just the pathologists, you're only counting those patients who have had biopsies at the hospital, not the ones who come in for treatment or for other reasons. Up to 20% of the cancer patients seen by the hospital may be lost to the reporting system simply because they are not operated on," Wilson says. "And because there is no follow up of patients in this method, as there are in the tumor registeries, mortality/survival statistics will never be available."

Follow up expenses for these survival statistics do not come inexpensively. In some cases, they may go as high as $140,000. But the information these kinds of statistics provide is invaluable.

So what now? Is it back to the drawing board for the Committee? In a sense, yes.

STAGE III: Exploring other systems

In his column in "Overview," Dr. Newton writes that: "other pilot proposals are being put together which could accomplish the same objective (a statewide voluntary reporting system). These will be considered by the Data Management Committee, and will serve as alternatives to accomplish the desired means of knowing just how many cancers develop in our state in a given time and place."

One such "pilot proposal" is currently in operation in Portsmouth, Ohio.

"We're receiving pathology reports as well as reports from the tumor registeries in that county. We'll get an opportunity to see how receiving the combined reports will work," Wilson says.

No matter what system may eventually result, perhaps the most positive thing to focus on in this whole trial and error process is the remarkable amount of voluntary cooperation going on between the Consortium and Ohio hospitals.

"The hospitals are really crucial to any reporting system," Wilson says. "They will make or break whatever system we decide on."

Ohio is unique in attempting its own incidence reporting system as a voluntary project.

"The other statewide reporting systems had theirs mandated by their state governments. It's to Ohio's credit that the Consortium wanted to set up an information system on its own — and it is thanks to the voluntary efforts of each hospital that any system is off the ground at all," Wilson adds.

There is still a long way to go, however.

"It takes time to get around to each hospital in the state — as we must if this is to be a true, statewide system — and explain who we are, what we are doing and why. We are working one region at a time in a phase-in approach."

By the first of next year, the Data Management Committee will have a report put together for the State Legislature which will detail its activity in getting a voluntary statewide cancer incidence reporting system off the ground in Ohio, — and what success it has had.

But members of the Committee are confident that, within five years' time, *some* sort of statewide cancer incidence reporting system will be operating in Ohio — in whatever form it takes.

Incidence reporting will generate hundreds of questions, and the Consortium will be there to go in for study and see what needs to be done.

Perhaps the rate of cancer in Cincinnati *is* alarmingly high, as some national studies have already indicated — and maybe a particular type of cancer will surface as prevalent in a certain age group among all Ohio females or males, and appropriate screening can be arranged, treatments researched, etc.

But until statewide figures are there to prove or disprove all the theories, no one is going to know how best to spend Ohio's cancer dollars.

The statewide cancer incidence reporting system is going to help narrow the field a bit, provide a target area, if you will, with its information. And whether the information is determined by pathology reports, a statewide tumor registry, or some other method not yet explored is academic. The important thing is that the system *is* getting off the ground, now, finally. And that's what it's all about. **OSMA**

Karen S. Edwards is Executive Editor of the Ohio State Medical Journal.

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Cancer Research:
Ohio's Contribution

By Susan Porter

At the Bob Hipple Laboratory for Cancer Research in Kettering, researchers are attempting to purify the hormone granulopoietin in hopes of answering some vital questions related to leukemia and other white blood cell disorders.

In Toledo, investigators at the Medical College of Ohio are working directly with industry, agriculture and government to uncover industrial-related carcinogens in the environment.

Scientists at Case Western Reserve University in Cleveland are hoping to discover ways to stimulate the body's enzymatic system and other natural defense mechanisms which will allow for DNA repair in cells chemically damaged by invasive malignancies.

Using monoclonal antibodies to deliver toxins directly to cancer cells without damaging normal cells is the goal of numerous researchers, including those at the Ohio State University in Columbus and Northeastern Ohio Universities College of Medicine in Rootstown.

These are just a sampling of the battles being waged all across the state in the war against cancer, an enemy that continues to claim the lives of some 440,000 Americans each year, including 21,500 Ohioans. And while significant victories have been won by scientists, physician investigators and other researchers leading the fight — to the recent landmark point where now half of cancer's victims overcome the disease for at least five years — much remains to be done to insure the remaining 50% can join the ranks of the survivors.

Without question, the most intensive battleground in the state is the Comprehensive Cancer Center on the campus of the Ohio State University, one of only 21 such centers in the country as designated by the National Cancer Institute (NCI). Soon, OSU will be the site of a new $50 million cancer institute hospital; ground will be broken in July for the 160-bed, 12-story facility which will be one of only four of its kind in the country when completed in late 1986.

Soon, OSU will be the site of a new $50 million cancer institute hospital, which could make Columbus a world leader in cancer research.

According to Arthur James, MD, professor emeritus of surgery at OSU, the center could make Columbus a world leader in cancer research; unlike other cancer hospitals in the nation, it will be an integral part of a major medical center and a university already actively participating in cancer research. The new cancer institute will contain a $10 million radiation department for both therapy and laboratory experiments, a daycare center where recuperating patients can receive chemotherapy on an outpatient basis, a 24-bed bone marrow transplant unit, operating rooms with state-of-the-art equipment, four floors of patient beds which will handle up to 4,900 patients a year, and two full floors of basic research labs.

The facility will offer its physicians and researchers the opportunity to study and work with rare and unusual forms of cancer, along with new treatments and equipment devised to treat these cancers. "The typical general hospital admits only 5% to 6% cancer patients — its staff is trained to deal with everything," Dr. James explains. "A cancer hospital deals with 100% cancer admissions. This higher concentration allows the staff to become more expert, particularly in dealing with the more unusual forms of cancer."

Already, over 500 researchers from eight colleges at OSU are involved in cancer research, according to David S. Yohn, PhD, MPH, director of the Comprehensive Cancer Center at OSU. Both basic and clinical research is taking place there today, although the new cancer hospital will allow for much more clinical research, he says.

"Ideally, cancer research involves a progression from the lab bench to clinical treatment," says Yohn, adding that most major breakthroughs have come from this kind of integrated effort at a major research facility.

Today, 15 departments and divisions of the College of Medicine at OSU are involved in a variety of cancer research projects, along with the colleges of veterinary medicine, biological sciences, pharmacy,

dentistry, nursing, agriculture, and physical and mathematical sciences. While most clinical research there is carried out by physicians, the basic research projects (65%-70% of the total) involve a variety of professionals, from biochemists and microbiologists to social scientists and mathematicians.

Notable accomplishments at OSU, according to Yohn, include discovery of the first effective vaccine to prevent leukemia in cats — now being used as a model for developing similar vaccines for virus-caused leukemias in humans. Another OSU researcher was among the first in the nation to demonstrate how chemical carcinogens interact with human cells to turn them into cancer cells, says Yohn.

OSU has conducted research activities for over half a century; yet it is not alone in the state in its efforts. All seven medical schools in Ohio are involved to some degree, along with a number of hospitals, universities and other public and private institutions.

Among them is Case Western Reserve University, designated a national cancer research laboratory center by NCI. At Case Western, about equal numbers of researchers are involved in basic and clinical projects; a major thrust is to determine how to stimulate the body's natural defense mechanisms to repair DNA cells damaged by cancer, according to information provided by Neil S. Cherniack, MD, professor of medicine there.

"Other investigators are attempting to enhance the effectiveness of current cancer therapy and to develop new therapeutic agents. Thus, cancer research at Case Western Reserve University has involved an integrated attack by both clinical and basic science investigators," a written report on the program says.

Like other research centers in Ohio, Case Western works with a number of nearby hospitals and institutions to form a cancer study group, allowing newly developed protocols to be tested on large numbers of patients in a clinical setting. One of the oldest such groups operating in this state is the Children's Cancer Study Group (CCSG), which involves children's hospitals in Cincinnati, Columbus, Dayton, Cleveland and Toledo.

According to William Newton, MD, chief of the department of laboratory medicine at Columbus Children's Hospital, study groups like CCSG provide doctors and scientists with enough cases to do valid and reliable studies. "It's a way of taking a rare entity (such as cancer in children) and fusing it together to give doctors enough experience to address some very complex questions," he says. "It would take us a lifetime to do something individually that this group can do in one or two years."

Ohio is not new to the fight against children's cancer; nearly 30 years ago, Dr. Newton was party to a major breakthrough in the treatment of leukemia, when he decided to treat patients with two drugs at the same time. Now multi-drug therapy has become commonplace, helping to push the survival rate for children with leukemia well over the 50% mark.

A major center of basic cancer research in the state is Battelle Memorial Institute in Columbus, which receives some $7 million per year in grants for that purpose.

"A lot of dramatic improvements have occurred over the past 27 or 28 years," Dr. Newton says. "Today, childhood cancer is much more likely to respond to drugs." And the principles, ideas and concepts used to treat children with cancer may also apply to adults, he says.

The Cleveland Clinic, another major center of cancer research in Ohio, is involved in four cooperative groups, including the Pediatric Oncology Group, a second nationwide cooperative focusing on children's cancer. In addition, the clinic participates with the Southwest Oncology Group, the Radiation Therapy Oncology Group and the Gastrointestinal Tumor Study Group, testing new types of radiation therapy and chemotherapy on patients, according to James Montie, MD, chairman of the cancer center at the Cleveland Clinic.

The clinic has a total of 37 scientists and physician investigators, plus nine pre and post doctoral fellows working on 77 ongoing cancer research projects, with a cancer research budget of over $1.5 million per year. Recently it was granted approval from NCI to participate in a biologic response modifier contract, says Dr. Montie, making it one of only 25 institutions in the country that can compete to use certain experimental anti-tumor agents such as interferon.

Cancer patients make up the second largest group at the clinic, says Dr. Montie. Over 2,100 new cancer patients are admitted there each year, making it, to date, the largest cancer treatment facility in Ohio and providing one of the largest settings for clinical cancer research in the nation.

On the other hand, a major center of basic cancer research in the state is Battelle Memorial Institute in Columbus which receives some $7 million per year in grants and contracts for that purpose. "Battelle has been involved in cancer research for over 25 years, when work was first started for the National Cancer Institute to evaluate potential antineoplastic compounds," according to information provided by Jeff Botti at Battelle. "Since that time, our efforts have widened to include cause, diagnosis and prevention, as well as treatment of cancer."

Projects currently underway at Battelle include assessment of the antineoplastic potential of approximately 10,000 compounds per year in the primary mouse tumor model (P338 leukemia). In addition, about 1,000 compounds a year are evaluated against B16 melanoma, Lewis lung carcinoma, $CD8F_1$ mammary tumor, C38 colon tumor and the M5076 ovarian tumor. "During the past six years, the most promising compounds have also been evaluated against human breast, colon and lung tumors growing in athymic mice," according to Botti's information.

In addition, Battelle has served for the past 10 years as the prime

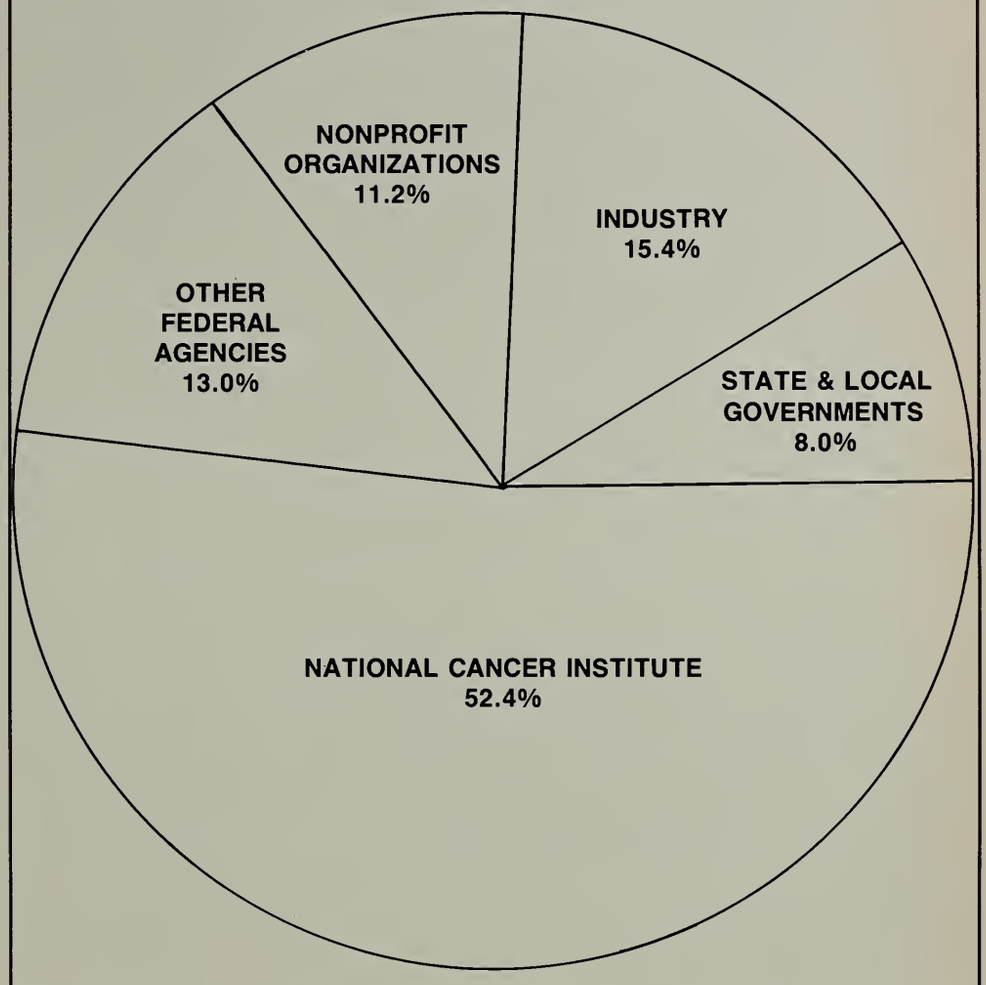
contractor for NCI's Toxicology Branch, managing and coordinating efforts to determine which antineoplastic drugs are suitable for use in humans. Battelle also has developed models to assess treatment of brain tumors, solid tumors and different forms of immunotherapy, in collaboration with clinicians at several universities, including OSU.

Cancer research also is taking place at the University of Cincinnati Medical Center, where 27 grants totaling nearly $3 million are currently underway, according to Eugene D. Jacobson, MD. Projects there range from "Studies of Experimental Pancrease Cancer" and "Collaborative Study in Lung Cancer by Statistical Group" to "Chromosomal Damage Inducted by Hyperthermia and Radiation" and "Follow up of Breast Cancer Screening Participants." Some 34 researchers from various departments at the school, including radiology, surgery, internal medicine, microbiology, biochemistry, anatomy, physiology, environmental health and otolaryngology are involved in these projects.

Even more individuals are involved in cancer-related research at the Medical College of Ohio in Toledo, where 66 full-time faculty members are engaged in this work. "Specific research programs of particular relevance include a number concerned with basic mechanisms of carcinogenesis, which relate directly to risk factors and epidemiological concerns," according to information provided by that medical school. In addition, five investigators there have been working "directly with industrial and agricultural businesses, local and federal agencies on a variety of questions and problems, including occupational exposure to hazardous substances and the monitoring of employees at risk; the possible contamination of water sources by industrial and agricultural sources and waste storage sites; and the disposal of waste materials."

Other cancer research projects are taking place at Ohio University in Athens, where three studies are underway, and at Wright State University in Dayton. Wright State also provides space for the Bob Hipple Laboratory for Cancer Research in Kettering, where scientists have gained world-wide recognition for their work with the newly discovered hormone granulopoietin, which regulates the production of white blood cells.

FIGURE I



Sources of Cancer Funding, Nationwide

(Figures provided by the National Cancer Institute)

At the Northeastern Ohio Universities College of Medicine (NEOUCOM) in Rootstown, several investigators are working with lectins and monoclonal antibodies as possible means to target poisons directly to cancer cells, leaving normal cells untouched. Also, the role of viruses and cancer is being investigated by one researcher at NEOUCOM, who also is developing a *flow cytometry* facility for rapid tumor identification and testing of chemotherapeutic agents.

Funding

None of these projects could take place without millions of dollars in funding allocated to cancer research each year. Surprisingly, most of that support comes not from charity but from the federal government, according to figures provided by NCI. The biggest single source of monies is the National Cancer Institute, which, as the largest division of the National Institutes of Health (NIH), has a budget of over $1 billion for 1984; of that amount, over 80% will go into cancer research.

Over $23 million in NCI contracts and grants currently are committed to researchers and institutions in the State of Ohio. The largest recipient is the OSU Comprehensive Cancer Center, which as a major arm of NCI, gets over $7 million for its projects, including over $1.7 million for construction of the new cancer facility. Battelle is second, with $4 million in contracts and grants from NCI, and Case Western is third, with

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Cancer Research

continued

over $3 million. Other institutions with over a million dollars currently committed to them by NCI include Ben Venue Labs in Bedford with $2.3 million contract, the University of Cincinnati with $1.5 million and the Cleveland Clinic with $1.2 million.

NCI is funding projects in lesser amounts at Monsanto Laboratory and at Wright State University, both in Dayton; Chemical Abstracts, Roxane Laboratories, Children's Hospital, the Worker's Institute for Safety and Health, the International Association for Comprehensive Research on Leukemia, and Grant Hospital, all in Columbus; Christ Hospital and the Children's Hospital Medical Center, both in Cincinnati; Toledo Hospital; Mt. Sinai Hospital of Cleveland; the Kettering Medical Center; Flower Hospital in Sylvania; and United Rubber in Akron.

According to figures provided by NCI, the National Cancer Institute provides 52% of all monies going into cancer research nationwide (See Figure 1). Another 13% comes from other federal agencies, including NIH, the Defense Department, the U.S. Environmental Protection Agency, the Department of Energy and the National Institute of Safety and Environmental Health. An additional 8% comes from state and local government.

Business and industry contribute over 15%, including philantrophic donations by the large oil, tobacco and auto companies. Pharmaceutical and chemical companies are among other large contributors, and many conduct their own research projects.

A mere 11% of the monies going into cancer research, nationwide, come from charitable organizations including the American Cancer Society (ACS) which last year funded some $57 million in cancer research projects. According to figures provided by the Ohio Division of ACS, that organization currently is supporting 16 grants in Ohio with funds totaling $1.7 million. These include projects at Case Western, OSU, the University of Cincinnati and Children's Medical Center in Cincinnati. In the recent past, ACS also has supported projects at the Medical College of Ohio, NEOUCOM, Cleveland State, Kent State and Ohio University.

Other projects throughout the state are financed by smaller groups. For example, the Fraternal Order of Eagles has committed $7,500 to two projects at Ohio University, while the Montgomery County Society for Cancer Control currently is funding a project at Wright State.

Most grants, including those from charitable organizations, are awarded for select kinds of projects, according to Yohn. "The National Science Foundation tends to support pretty basic research. For instance, you might be studying the biochemistry of a yeast; what you find out has a relationship to biology and therefore to cancer," he explains. The Air Force, on the other hand, is more interested in supporting projects related to certain exposures its personnel might encounter, while the EPA tends to support environmental studies of a general nature.

In spite of multiple sources of funding and the host of different methodologies being tried to fight cancer, researchers agree there is a shortage of manpower and supplies in this state.

"The only institutions that are truly broad-based in their willingness to fund a whole spectrum of cancer-related projects are the National Cancer Institute and the American Cancer Society," says Yohn.

In spite of the multiple sources of funding and the host of different methodologies being tried to fight cancer, researchers agree that there is a shortage of both manpower and supplies in this state. It is in this respect that both Yohn and Dr. James feel the new Cancer Research Institute, which will cost Ohio taxpayers $40 million, will be a good investment.

Not only will it offer Ohio physicians the most up-to-date setting for the study and care of their cancer patients; it also will draw more funds for both basic and clinical research to this state, says Yohn. "It will attract additional competent clinical research investigators who, in turn, will attract more and larger grants from granting agencies. In effect, it will greatly increase the monies coming into Ohio for cancer research."

Already, says Yohn, Ohio has played a major role in the war on cancer. "We've developed a cancer center here ranked among the top ten in the nation," he says. "We've attracted a significant number of basic research scientists interested in what causes cancer and what we can do to prevent it."

And with the new cancer research facility finally becoming a reality, Ohio could well become the number-one leader in the nation's fight against the number-two killer of its citizens. "The research done here not only will lead to saving lives," says Dr. James. "It also will lead to solving the cancer problem, which, in many respects, is even worse than heart disease, because it causes so much more suffering." **OSMA**

Susan Porter is assistant editor of the Ohio State Medical Journal.

Heroin overdose deaths increasing

The number of deaths and emergency room admissions due to heroin overdose has increased dramatically in the past three years according to the Drug Enforcement Administration.

Deaths from heroin overdoses have risen 63% since 1980 and the number of emergency room admissions has risen 48% in the same period of time. There were a total of 11,538 ER admissions and 771 deaths related to heroin use in 1982.



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Cancer Management: 1984

By Robert W. Kellermeyer, MD; Roger H. Herziz, MD; Hillard R. Lazarus, MD; and Thomas R. Spitzer, MD

The management of malignant disease has evolved rapidly and continuously during the past 20 years. Adjuvant chemotherapy, combination chemotherapy, multimodality therapy, radiotherapy with fast neutrons, selective perfusion of involved organs with chemotherapy, biologic modifiers, treatment with monoclonal antibodies, allogeneic and autologous bone marrow transplant, and laser surgery — these are some of the relatively new and exciting approaches to cancer therapy being used in the eighties in Ohio.

To utilize these treatments appropriately, the histologic diagnosis must be firmly established and the extent of the tumor determined by staging techniques. Imaging of the tumor, both primary and metastatic disease, by isotopic scans, standard x-rays, computerized axial tomography (CT scans), and nuclear magnetic resonance (NMR) allow us to "see" the tumor when it is as small as 1 cm. and accurately determine the extent.[1] Soon, we will be using positron emission tomography (PET scan), as well, for tumor evaluation.

CT directed biopsy of a tumor mass,[2] endoscopy or surgery are also used to establish the diagnosis and staging of a tumor when necessary. Chemotherapy, radiotherapy and surgery are then used singly or in combination (multimodality) to treat the primary and/or metastatic malignant process. The use of all of the modalities, either singly or in combination, should be considered at the outset of management planning for each patient to achieve the maximum level of control or cure.

The following up-to-date forms of evaluation and management of malignant tumors are available at our institution and many other medical centers in Ohio.

Chemotherapy for extensive or metastatic disease

Chemotherapy can be curative when used as the primary form of treatment in advanced testicular carcinoma, small cell carcinoma of the lung, acute non-lymphocytic leukemia, acute lymphocytic leukemia, advanced Hodgkin's disease, diffuse histiocytic lymphoma and choriocarcinoma. The cure rate may vary from 10% to 80%, depending on the type of tumor and the general health status of the patients.

These cures are achieved at medical centers that have expertise in pediatric and medical oncology coupled to effective support from blood component therapy and physicians expert in infectious diseases. To improve on these results, we are utilizing local innovative experimental treatments, as well as national protocols, in collaboration with the Southeastern Cancer Study Group. All of the major medical centers in Ohio are similarly involved.

Adjuvant chemotherapy

Treatment with CMF (Cytoxan, methotrexate and 5-FU) following primary surgical therapy of breast cancer prolongs the disease-free period of survival in premenopausal women but may not be of value in post-menopausal women.[3] An ongoing study at Case Western Reserve University suggests that tamoxifen plus CMF may prolong the disease-free period in both premenopausal and postmenopausal women following mastectomy and ovariectomy.[4]

There is a small survival advantage for patients with Dukes' C1 colon cancer (involving four or less lymph nodes and the bowel wall)[5] given adjuvant 5-FU but not for those patients with more than four lymph nodes containing tumor. Adjuvant chemotherapy with 5-FU and nitrosourea may also be of value following primary therapy of Dukes' B2 and C rectal carcinoma. There is no beneficial value of adjuvant chemotherapy in other malignancies, including renal, testicular, bladder, lung, prostate or malignant melanoma; therefore it should not be used other than in experimental studies.

Perfusion chemotherapy

Uncontrolled studies done in the past several years have not demonstrated a survival advantage following arterial perfusion with chemotherapy to head and neck tumors or limb tumors. Recently, nonrandomized studies have suggested there may be a survival advantage when metastatic adenocarcinoma of the liver is treated with intermittent continuous hepatic artery perfusion with 5-FU or FUDR using external or implantable pumps for the chemotherapy infusion,[6,7] although this is still controversial.[8]

Bone marrow transplant

Both autologous and allogeneic bone marrow transplant have been successfully used to reconstitute the bone marrow after elimination of the

malignancy by marrow lethal dosages ("high dose") of chemotherapy. This technique has now been successful in acute myeloid leukemia, acute lymphoblastic leukemia, lymphoma, malignant melanoma and perhaps other solid tumors.[9,10,11] Prior to the high dose chemotherapy, marrow is removed under anesthesia by aspiration from the posterior iliac crests of the pelvis of the patient (for autologous marrow graft) or from the matched donor (for allogeneic marrow graft). This marrow can be stored in the frozen state for several years in liquid nitrogen. The marrow can be easily thawed and returned to the patient by intravenous injection. More than 350 marrow donations have been stored at University Hospitals of Cleveland during the past five years, and half of these have been used.

Allogeneic bone marrow transplant (matched marrow obtained from a sibling donor), following disease ablation with high dose chemotherapy and total body irradiation (TBI), has been effective in acute leukemia, chronic myeloid leukemia and lymphoma. Of 16 patients with acute lymphoblastic leukemia in first or second remission treated with a marrow lethal dose of cytosine arabinoside, total body irradiation and allogeneic marrow transplant, there has been only one relapse; 11 have been alive one to 34-plus months, with a 58% actuarial survival at two years.[12] During the past five years, approximately 100 allogeneic bone marrow transplants have been done at University Hospitals of Cleveland. Studies are now in progress utilizing immunologic modulation eg. monoclonal antibodies, to control the graft versus host disease that often develops.

Since allogeneic marrow transplant is limited by the availability of an appropriate donor, as well as age and graft vs host disease, autologous marrow transplant has been used to reconstitute the bone marrow following treatment with marrow lethal doses of chemotherapy, both with and without total body irradiation for solid tumors and resistant lymphomas. This program is based on the premise that effective doses of chemotherapy for some tumors are limited by the drug induced myelosuppression; the latter could be circumvented by marrow transplant following chemotherapy. At the present time, the marrow must be free of the patient's malignant tumor, yet research techniques are now available to "purge" the marrow of small amounts of malignant cells with monoclonal antibodies for certain malignancies.

Our data indicate that lymphoma and malignant melanoma can be effectively treated by high dose chemotherapy and autologous marrow transplant following resistance to conventional chemotherapy.[10,11] Fifty-two patients with malignant melanoma have been treated at University Hospitals of Cleveland with high dose BCNU and melphalan, either singly or in combination, in both phase I and phase II studies. Of the 52 patients treated with these regimens, there was a 67% response rate including, 11 complete remissions and 24 partial remissions. These responders have survived a median of six months (range: one to 38-plus months), with 21% of the responding patients having a duration of response of one year or more. This is most impressive when contrasted with a maximum of 20% overall response, including less than 5% complete response, in metastatic malignant melanoma treated with standard chemotherapy. Dosages of BCNU and melphalan, used in combination, have now been established, and a phase II study is in progress.

Our data indicate that lymphoma and malignant melanoma can be effectively treated by high dose chemotherapy and autologous marrow transplant . . .

In a similar program, 47 patients with lymphoma in relapse have been treated with high-dose cytoxan and total body irradiation.[10] Twenty-five of 41 patients evaluable for tumor response (61%) have achieved a complete remission. The median duration of unmaintained remission is 11-plus months, and nine patients are alive and free of disease for more than one year (longest five-plus years).

Other applications in marrow transplant are being evaluated for breast cancer, colon cancer, small cell cancer of the lung and ovarian cancer in adults and selected pediatric solid tumors.

Biologic response modifiers:

Agents whose anti-tumor activity is thought to arise from modulation of the immune system are termed biologic response modifiers. One such group of agents, the interferons, have been the subject of numerous investigations recently. These naturally occurring proteins are known to have potent antiproliferative, antiviral and immune stimulating properties and have, therefore, been utilized in clinical trials involving patients with neoplastic diseases. Early studies using human leukocyte interferon demonstrated significant anti-tumor effects, including objective remissions in lymphoma, multiple myeloma and breast cancer;[13] more recently, impressive results were reported in hairy cell leukemia with seven of seven patients achieving a partial or complete remission with leukocyte interferon.[14] Drawbacks of this therapy, however, have included impure preparations which have relatively little biologic activity. Subsequently, purified preparations derived from recombinant DNA technology have been studied in numerous phase I and II trials. Encouraging results have been reported with the use of recombinant leukocyte A interferon with objective anti-tumor activity observed in lymphoma, chronic lymphocytic leukemia, breast cancer and melanoma.[15] Human gamma interferon (derived from activated T lymphocytes) has also been studied and appears *in vitro* to have enhanced antiproliferative activity; early trials have not substantiated improved anti-tumor activity, however. Cooperative group studies with interferon are currently in progress at our institution

and others in Ohio. Toxicity of the interferons has been predominantly constitutional (fever, myalgias, headache, etc.) although hematologic toxicity (leukopenia and thrombocytopenia) has also been observed.

Hypoxic sensitizers:

The inability to effectively eradicate many malignant tumors with conventional radiation therapy and chemotherapy has been thought to be due in part to a central hypoxic region of the tumor. One approach to this problem has been to use substances which mimic the sensitizing effects of oxygen and consequently improve the therapeutic ratios of standard radiation and chemotherapy.[16] Misonidazole, an analogue of metronidazole (Flagyl), has been shown to significantly enhance radiation induced cell kill in numerous animal tumor models. Disappointing results have been observed in human studies; however, this is in part due to a dose limiting peripheral sensory neuropathy which has developed in some patients.

Misonidazole has also been reported to enhance alkylating agent cytotoxicity in animal tumors without a substantial increase in myelotoxicity. The mechanism of action has recently been determined to be due to the ability of misonidazole to increase alkylator induced DNA cross links.[17] Studies just beginning at University Hospitals of Cleveland involve the combination of desmethylmisonadazole, an active metabolite of misonidazole, with high dose melphalan and autologous bone marrow transplantation in the treatment of certain advanced malignancies. The purpose of these studies will be to determine whether an increase in the already observed high dose melphalan induced tumor regressions will occur with the combination of high dose alkylating agent and a hypoxic cell sensitizer.

Monoclonal antibodies:

The diagnostic and therapeutic power of a drug or chemical that would go selectively to tumors within the body and not to other tissues is enormous. Tumor could be detected when present in only small quantities and therefore allow specific and early treatment. Treatment directed only to the tumor cells would eliminate many of the toxicities that we encounter with chemotherapy and radiotherapy. The monoclonal antibody may offer this opportunity, since it can be developed to a specific and unique part of the tumor cell. Tumor cell death could be produced by the antibody alone or by cytotoxic chemicals or isotopes attached to the monoclonal antibody.

The manufacture of monoclonal antibodies utilizes the technique of hybridization or fusion of a myeloma cell with a spleen cell or lymphocyte; the latter are taken from mice immunized with the patient's tumor cell and contain the DNA message for the synthesis of the antibody.[18] The fusion of the myeloma cell and the spleen cell results in a hybrid cell with the DNA message from the spleen cell built into the myeloma cell which can now produce the antibody for which the spleen cell was programmed.

Monoclonal antibodies against tumor cells have been produced and are being tested in patients with leukemia and lymphoma.

Monoclonal antibodies against tumor cells have been produced and are being tested in patients with leukemia and lymphoma.[19,20] Miller, et al. reported the intravenous injection of monoclonal antibodies could transiently decrease circulating leukemic cells or shrink tumorous skin nodules in patients with chronic lymphocytic leukemia or cutaneous T-cell malignancies.

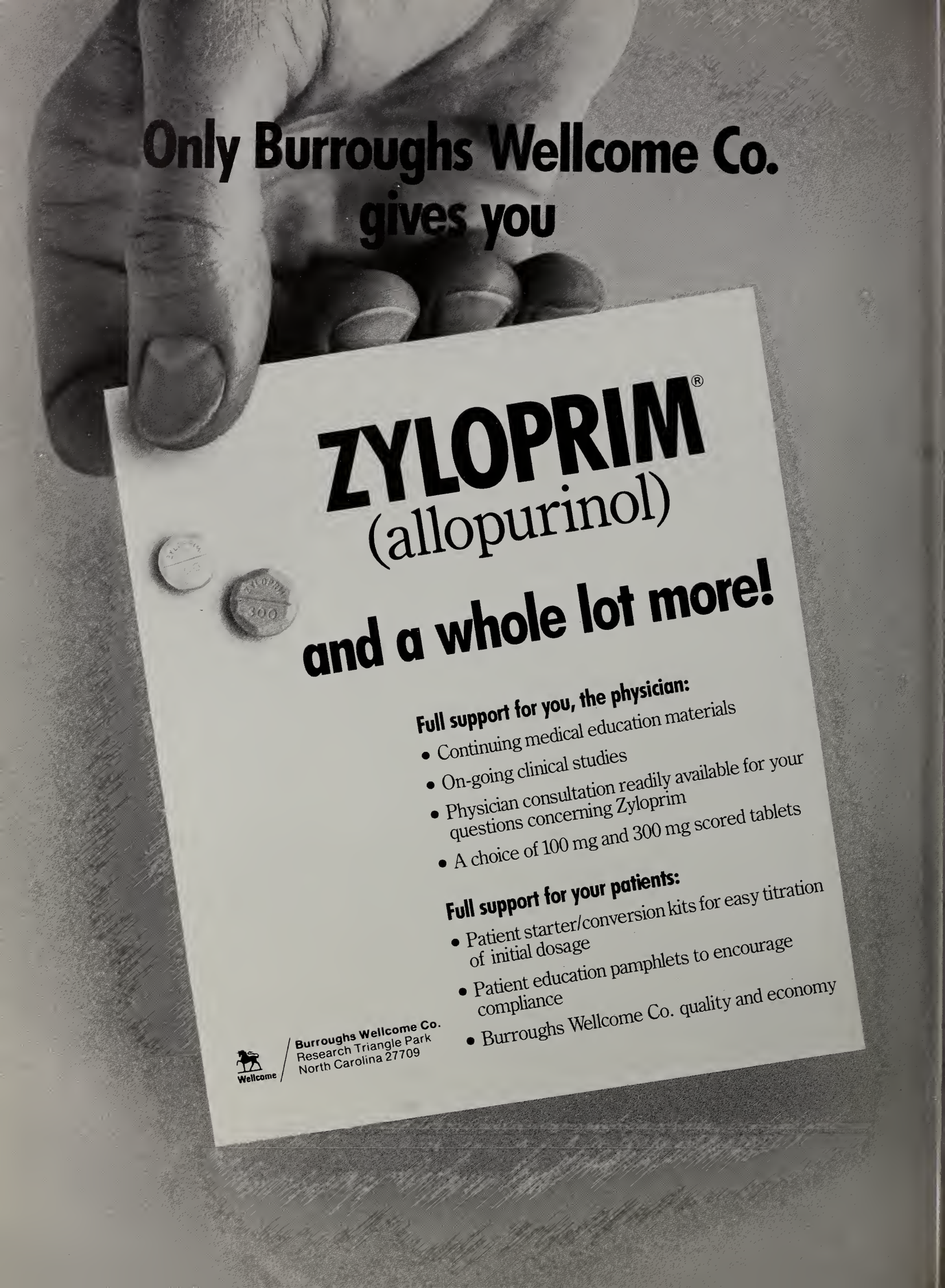
Problems arose with antibody injections and included fever, chills, dyspnea, hypotension, rash, and anaphylaxis. Other problems included cross reactivity of the antibodies with both normal as well as malignant cells, binding of antibody to circulating free antigen rather than cellular antigen, development of human anti-mouse antibody, and antigenic modulation. The latter involves the shedding of the target antigen by the malignant cell soon after antibody exposure.

Miller, et al. used anti-idiotype antibodies (derived specifically for that patient) to circumvent some of these problems and were able to achieve a long-term complete remission in a patient with B-cell lymphoma. Other solutions included the use of immunoconjugates, antibody "cocktails" (mixtures of antibodies against several antigens or epitopes), plasmaphoresis to remove free antigen, human-derived antibodies, and induction of tolerance.

Another approach is the *in vitro* use of monoclonal antibodies, specifically marrow "purging." Marrow can be treated *in vitro* at 4°C to decrease modulation. Cells then can be mechanically removed, or lysed with complement. Studies are underway in which monoclonal antibodies or immunoconjugates are used *in vitro* to remove immunocompetent T cells from normal donor marrow during allogeneic bone marrow transplantation to prevent graft-versus-host disease. Initial results seem promising with a decrease in graft-versus-host disease. However, early infections, the possible development of lymphoma at a later date, and graft rejection have been major concerns (the latter occurring in those who received a less intense immunosuppressive regimen). Similarly, residual (occult) tumor cells may be removed or lysed from patient (autologous) marrow before re-infusion. Many transplant programs now are using purging techniques for patients with leukemia, lymphoma, and neuroblastoma. While a great deal of work needs to be done to define the role of monoclonal antibodies in therapy, the future is bright in this area of cancer biology.

Summary

Cancer management is moving into a new era. Diagnosis and tumor characterization will include not only


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Cancer Management

continued

CAT scanners but NMR and PET scanners. While surgery, radiotherapy and chemotherapy are the standard modalities of therapy, the use of new tools including monoclonal antibodies, biologic modifiers such as interferon, bone marrow transplant and hypoxic sensitizers will offer more sophisticated and effective modalities of cancer therapy. These techniques are either available or are being developed at our Cancer Center and other institutions in Ohio.

The combined or integrated early use of these treatment forms is important to achieve the maximal beneficial effect. This emphasizes early detection, thus permitting treatment on smaller primary tumors with absent or limited metastatic spread. Prevention and research related to our understanding of etiology and control of cancer must receive equivalent emphasis. **OSMA**

Dr. Kellermeyer, Professor of Medicine, American Cancer Society, Clinical Professor of Oncology

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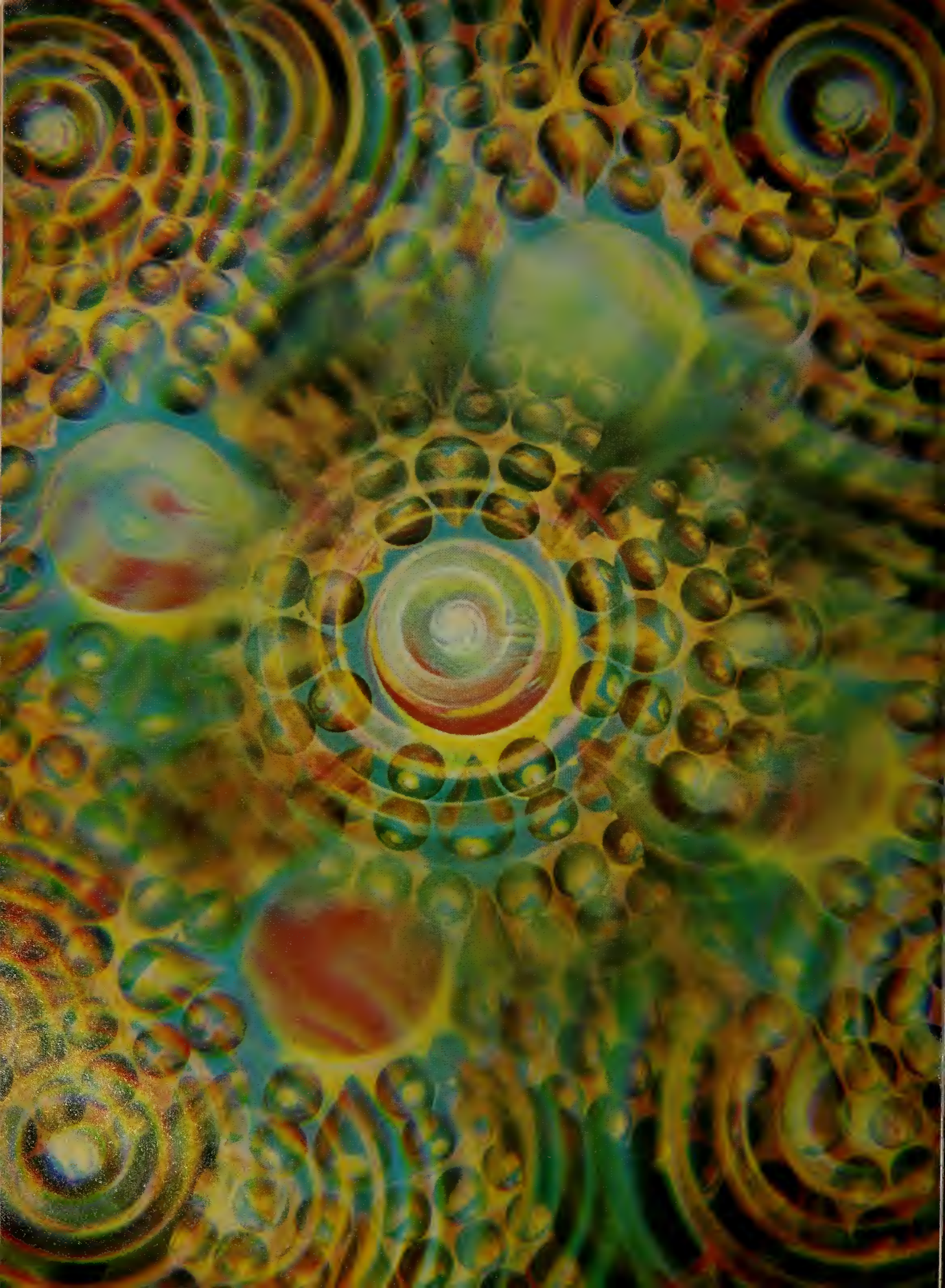
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Handling Cancer's Emotional Side

By James R. Hodge, MD and Massood Babai, MD

The simple word "cancer" strikes fear into the hearts of thousands of people every year. Some are so afraid of cancer that they insist on a medical checkup for any small change of body functions, such as the patient I once had who had a "cancer-of-the-month" for a long period of time. Others are so afraid of it that they *and their relatives* may deny the possibility that a symptom might be of cancer, as was the case of a woman whose mother and grandmother had died of cancer of the breast. She found a lump in her breast and decided to wait for me to check it at her next appointment a whole month away!

Families really should ask for help. It helps others to help them. Everybody is worried about the patient, but nobody is worried about the family, and they need help at least as much as the patient does.

Who Gets Cancer?

There is nothing new in the idea that emotions are linked with cancer. Since at least the 1950s, research, experience, and statistics have shown that the onset and the relapses of cancer tend to follow a period of prolonged stress or the occurrence of a specific stress (especially the loss of a loved one, depression, despair, helplessness, and hopelessness),[1] and that this *may* coincide with acute or chronic exposure to a carcinogen. For example, animal research shows that mice bred to develop breast cancer and reared in stressful environments developed cancer earlier than those in non-stressful environments. Just as cardiovascular disease is more frequently found in the "Type A" (achievement oriented) personality, so is cancer alleged to be found in the more passive and depressed personality described above. But these statistics alone are not discriminative. It is really not only the life events themselves, but also how a person perceives and copes with them that influences susceptibility to disease.[2] A person who copes well is able to fend off disease, including cancer, better than one who copes poorly.

Linn,[1] in an ongoing study of smokers, found that those who developed lung cancer had the same number of stressful life events as those who did not, but they *perceived* those events as more stressful and perceived themselves as more responsible for bad results. The immune variables

studied correlated significantly with perceived stress. A year later, the cancer group showed more depression, somatization, and decrease in internal locus of control. The changes are felt to be the result of the experience of having cancer. Fox[3] offers the interesting concept compatible with the above theories that "people who are fighters, complainers, and who just don't accept the disease . . . may have a longer interval before they relapse than those who accept the disease."

What this all boils down to is that a person who is leading a reasonably stress-free life and/or who copes well with stress is less likely to develop cancer, but if he/she does, he/she should complain, fight it, take the treatments, and "reject" the illness psychologically as the immune system attempts to do physiologically. Fighting the cancer is a different behavior and may be protective; "adjusting" to cancer often means not resisting it and could prove fatal.

The Psychological Stages of Adapting to Cancer

It is appropriate to look upon the responses to cancer as being similar to that of a Post Traumatic Stress Disorder. When the diagnosis of cancer is made, the following sequence of reactions occurs:

1. Shock, surprise, and fear, with the immediate reaction of feeling numbed, anesthesized, and unable to think or feel. Patients forget what they have been told and are often unable to make realistic decisions.
2. Emotional release, crying, suffering despair and anxiety. This release is good for the patient.
3. Exaggerated physical distress, with exacerbation of all symptoms and the appearance of new ones which are often due to anxiety.
4. Panic. The patient can almost feel the cancer spreading through his body. He believes that he is destined to die an agonizing death. He cannot stop thinking about cancer. He is suffering severely, and he needs realistic reassurance.
5. Guilt. The patient starts to wonder, "Why me?" and "Why now?" He needs to be reminded that cancer is not a punishment from God, not the result of sin, is not contagious, and is not a social disease. Sometimes patients in this stage feel so despairing that they consider or attempt suicide.[4]
6. Anger and resentment. In the stage of guilt the patient blamed himself; in the stage of anger he blames someone else. Objects of anger include God, the doctor, the government, the hospital, etc. Some people even turn on their loved ones.
7. Bargaining, which should be interpreted by the counselor as pleading. "Just keep me alive until my son graduates from grade school . . . then from high school . . . then from college . . .," etc.
8. Depression. When bargaining and pleading fails, depression develops, that giving-up, given-up state of being. This is the stage we recognize the most,[4] but it is neither the most nor the least important for the psychological well-being of the patient. It should be viewed as a *critical* stage because if the patient becomes blocked there, he may tend to suicide and/or to stop fighting the illness which worsens the prognosis.
9. Adjustment and acceptance. Adjustment and acceptance with surrender to the illness could be fatal. The adjustment and acceptance mentioned here refers to a realistic acceptance of the presence of the illness, the possibility of recurrence, the need for the treatment, and the willingness and ability to fight and reject the cancer.
10. The "five-year cure." Most patients become aware of this concept. It tells them that they should worry for five years, and they do; they only worry *less* after the five year span, but they don't stop entirely. And if relapses occur, the whole process repeats itself with more intensity.

Living with Cancer

The health professional should be aware of "The Seven Ds" of living with cancer:

1. The diagnosis. "The health professional can never be certain if, when, or how much to tell."[5] A guideline is that if knowing will influence the treatment, the life expectancy, or the "personal affairs," the patient should be told. In today's world it is hard to think of who should not be told. Once the patient is informed, he/she goes through the adjustment stages described earlier. He/she may go through any stage rapidly or slowly, but the total adjustment takes at least five years for the "five year cure."
2. Disfigurement. Sometimes from the illness, sometimes from the treatment, and sometimes only in fantasy, there is disfigurement which impairs physical abilities, social relationships, and feelings about the self.
3. Disruption. Lifestyle, social relationships and self concept are disturbed.
4. Disability. Whatever degree of physical disability exists may be increased or decreased by psychological factors.
5. Discrimination. The disfigured and disabled person will certainly feel the effects of discrimination, and the known cancer patient experiences it even if he/she is not disfigured or disabled. Social life is impaired, intimate life is impaired, and it is difficult to maintain a job.
6. Dysphoria. The disphorias of anger, resentment, anxiety, and depression continue as described earlier. Depression is the deadliest of emotions. The depressed patient does not participate in treatment. His/her bodily resistance is down; he/she is subject to infections and rapid tumor growth. In a sense he/she is committing suicide. The real antidotes for depression are results, hope, a feeling of being helped, realistic awareness, planning for the future, religion,

and psychotherapy. Medicines may help to a degree in some cases.[4] Anxiety is a more active emotion, and when it leads to resistance it is better for the patient. These dysphorias are so often ignored by everyone that the patient has to wonder if there is a "conspiracy of silence" about him/her condition and whether people are keeping things from him/her.

7. Death and dying. The stages of dying elaborated by Elizabeth Kubler-Ross[6] are so well known that I will only review the titles here: Shock, denial, anger, bargaining, depression, and acceptance. People confronting death will, most of the time, say that they really do not fear death but that they do fear the process of dying with the anticipated pain, agony, loss of control, and loss of dignity. They are usually quite willing to talk about this, and find it of great benefit.

Don't Forget the Family

The family is bothered by the same seven Ds that are so agonizing for the patient, and they are also deeply involved in the patient's psychological reactions to the illness. The family members recognize that they have an almost overwhelming role in the treatment of the patient. This makes them anxious, helpless, and depressed. They don't know what to do or how to do it. They don't know what to say or how to say it. They are afraid to stay with the patient but afraid to leave him/her alone. They need help. Friends and relatives often offer help which families reject. Families really should ask for help. It helps others to help them. Everybody is worried about the patient, but nobody is worried about the family, and they need help at least as much as the patient does. Their futures are in jeopardy too.

Getting Help

There is much help available for the psychological problems of cancer as well as for the physical aspects. It is there for the asking. There are many types of counselors, including psychiatrists, psychologists, social workers, ministers, and compatriots in support groups such as oncology support groups, Reach for Recovery, and other cancer self-help groups. The National Cancer Society is ready, willing, and able to help. Home health care is available from the Visiting Nurse Association and other organizations. Sometimes the attending physician recommends these and sometimes he/she does not know about them. If the doctor does not recommend them, the patient should ask about them.

Some Final Words of Advice

Here are some final words of advice for the physician and counselor:

1. Help your cancer patient *live* with the illness. Help him/her not to become a chronic invalid, but to do everything of which he/she is capable, especially the things he/she has always wanted to do. This is the time for the patient to catch up with any unfinished business in life. Help him/her make every good moment count.
2. Talk about it realistically and openly, reminding your patient that it is not a sin or a social disease. Encourage him/her to talk about it with family and friends. Help your patient to reveal his/her fantasies, but to separate them from reality.
3. Respect the patient and the illness. Cancer may not always be fatal, but it often is. Remind your patient that some cancers may kill or disable, only if not treated. Encourage your patient to participate in the entire treatment program even if it is uncomfortable. Remember that cancer is serious and a chronic illness; participate with your patient throughout the entire course of it.
4. Be a good and trustworthy person. Be realistic with the patient about his/her condition, progress, and prognosis. Discuss the medicines, the treatments, and the patient's feelings about them. Discussing the prognosis should emphasize encouragement and hope with as much reality as possible.
5. Encourage the patient and the family to join self-help cancer support groups and to participate in them. It is amazing that so many professionals know so little about these. Remind the patient that he/she is not alone.
6. Encourage your patient not only to *accept* assistance from friends, neighbors, and relatives, but to *ask* for it. They will be insecure about volunteering, but will be honored to be asked.
7. Help your patient to live life in day-tight compartments. Encourage him/her to think of the future, but live in the present. Remind your patient that periods of misery will pass and to enjoy it when he/she is feeling good.
8. Teach your patient the Serenity Prayer: "Lord, give me the strength to change the things I can change, the serenity to accept what I can't change, and the wisdom to know the difference." **OSMA**

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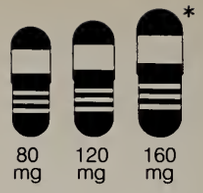
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INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end-diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the cranial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses at least 10 times greater than the maximum recommended human dose. There are no adequate and well controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Essay

Never Underestimate Charisma

By George D. Clouse, MD

My grandfather always went first class. He had one of the finest collections of split-bamboo, 10-foot fly casting rods available, each with the maker's name engraved on it, made expressly for him. He had one of the first telephones in Columbus and the number was 114.

He also had the most amazing treatment machines I have ever heard of. But first, it is necessary to picture the state of medical practice in 1908 when he got the machine. Nearly all MDs were family doctors who carried a bag with many vials of colored pills. Some people preferred the red pills to the green pills and vice versa.

Other than morphine and castor oil (with their predictable results), there was practically no such thing as a specific or effective drug for anything.

I have been told my grandfather was adept at "setting" bones and delivering babies, but almost all other medical practice depended on the doctor's charisma or magic.

Sometimes even the colored pills of aconite, gelsemium, etc. failed, and most doctors had some sort of medical gadget or gizmo for difficult cases. There wasn't much else they could do. No psychiatric referrals.

This machine my grandfather had was a bakelite table on which the patient would lie. From each corner rose a brass ball. Connected to the rods were wires running to a static electricity maker, a large disk with brass buttons on each side near the edge with brass brushes to pick up the charge. The wheel was cranked vigorously by hand and within 30 seconds blue static electricity bolts snapped and crackled between the balls which glowed with a blue halo. The patient's hair would stand on end!

After about five minutes it was stopped, the patients would arise "feeling better" or too scared to say they weren't. Otherwise they would get another dose. After that treatment they *had* to be better!

Now jump ahead to Columbus in the early 1940s. The use of leeches had long since faded, as well as Lydia Pinkhams and high alcoholic herbal nostrums. High colonic irrigations were passé and there were very few naturalopaths and homeopaths.

There was, however, in Columbus at that time a doctor who treated patients with a "gas chamber." After World War I, there were several medical papers written that claimed people exposed to *minimal* amounts of chlorine gas were less prone to have respiratory ailments. The climate of Columbus was a fertile field for this type of condition, and patients made a steady stream to his office from morning until night. He had a tank of chlorine gas, a valve, and a tube leading into the gas room. It was pale green, no windows, almost totally dark and furnished with a large padded wicker rocking chair. Patients would sit in this darkness for 10 minutes and breathe a faint odor of chlorine, such as that around swimming pools. Some of the time he would forget to turn on the chlorine — which was perhaps just as well. But people came from his room refreshed and "cured."

With all the giant strides made by medical science, there must be something lacking or else so many would not resort to other methods of healing.

In retrospect, his treatment was probably effective because people found a tranquil and undisturbed respite from the busy world and probably meditated in the darkness.

In primitive tribes today, there are still many witch doctors, medicine men and ritual healers. Even in our society, there are locations of reputed healing such as Lourdes. There are faith healers, food faddists, megavitamin advocates, Laetrile followers, herb healers, hypnotists, acupuncturists, and those who staple the ear lobes.

Is this all poppy-cock? Even Jesus Christ, with his miraculous healing power, would probably be labeled today as a quack. At least today's insurance computers would certainly reject his cures.

Yet with all the giant strides made by medical science, there must be something lacking, or else so many of the peoples of the world would not resort to other methods of healing. Even so, the advances made by modern surgery, chemotherapy, blood, and oxygen are miraculous in themselves, and no one with a serious ailment should consider anything else. Certainly, a compound fracture will not heal itself, and faith healing of



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Never Underestimate Charisma

continued

any kind won't help a gangrenous appendix. The man who deliberately let a rattlesnake bite him and attempted recovery by absolute faith was an utter fool.

On the other hand, the power of the mind to cause illness and also to restore health has been well documented. Perhaps it is a state of the *spirit* rather than the mind that causes even patients with serious illnesses to get along better or worse, depending on what they think. If they really *think* their treatment will help, they will do better than the patient of little faith.

There is an ever-present danger that those who could be helped by modern medical and surgical techniques will put themselves in the hands of some kind of faith healers, instead of the conventional and the orthodox care that might save them.

On the other hand, so very many people's ailments are psychosomatic or directly dependent on their state of mind, that great numbers of faith-type healers are needed to treat the gray areas of milder ailments that are so common. Conventional medical practitioners would be overwhelmed if they had to cope with baffling psychosomatic problems.

Modern medical training focuses on treating the serious ailments and shuns, scorns, condemns, and even prosecutes any unorthodox treatment because its magic or charisma cannot be measured or duplicated. Yet in any community, there is at least one physician who uses unorthodox procedures and methods that are not standard. He probably is charismatic and has a multitude of devoted patients, not one of whom has entered a complaint about him, even though most physicians would call him a quack.

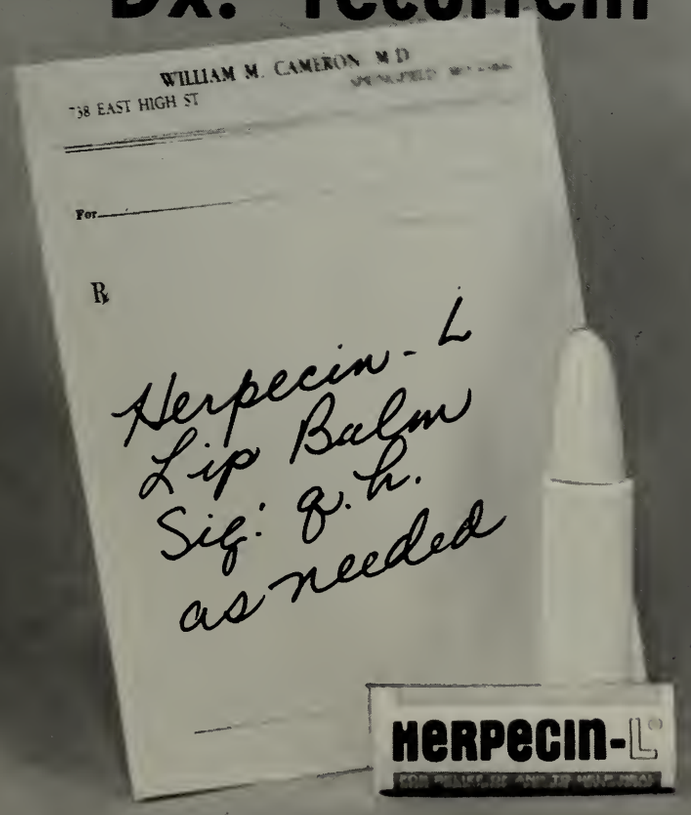
Keep in mind that a recent study of 4,500 patients showed that the physician's interest in the patient as a *person* was the most important factor in his or her recovery from illness.

Usually the physician with charisma or magic has only to walk into the room for a patient to feel better. There must be something there for people whose condition cannot be remedied by surgery or a specific drug. True, it can't be scientifically measured, but don't underestimate it.

When a child is injured, how can you measure the healing power of a parent's hug or a kiss? **OSMA.**

George D. Clouse, MD, is a family practitioner in Columbus, and serves as a member of the OSMA's Art and Culture Committee.

Dx: recurrent herpes labialis



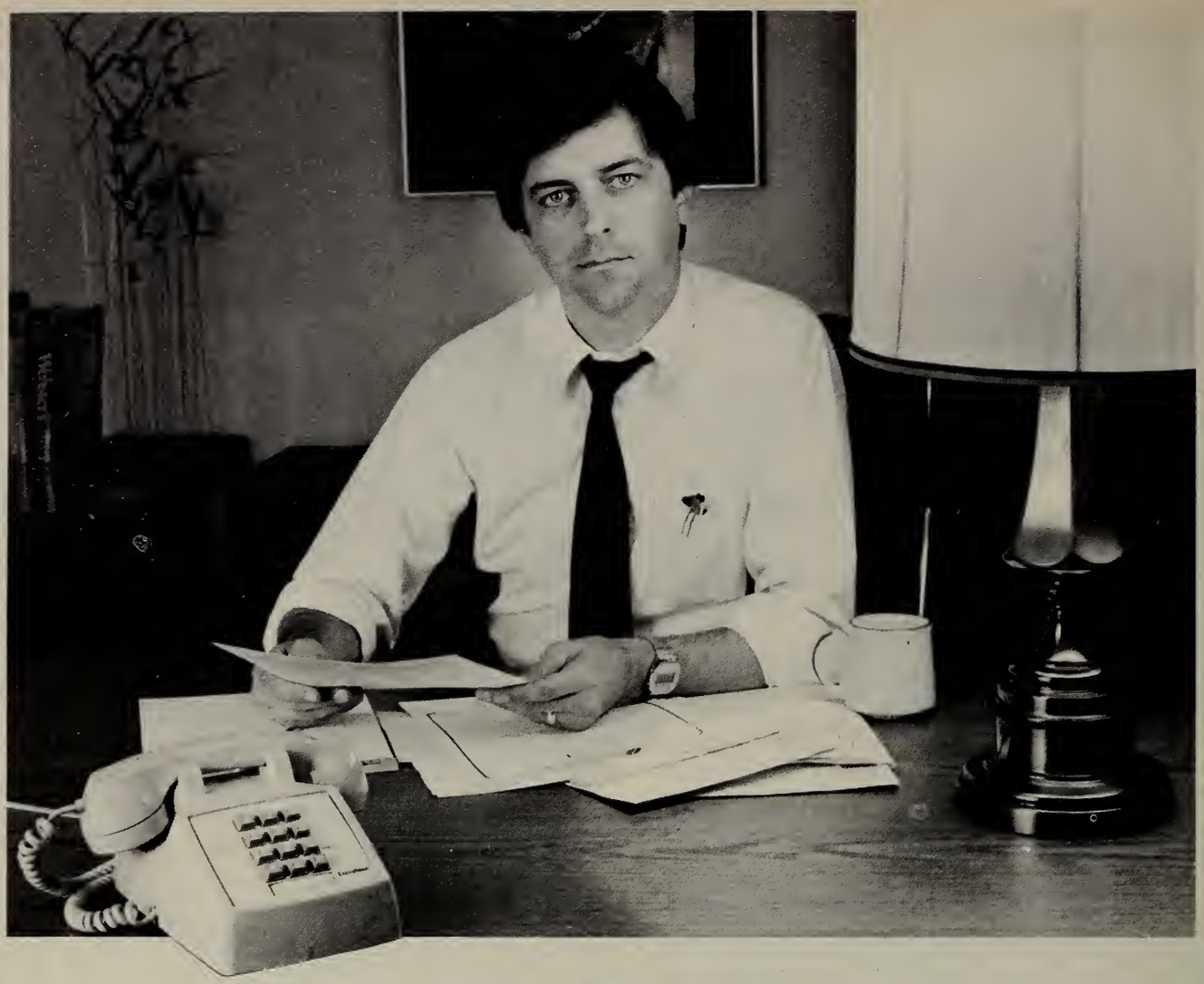
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Medical Board Establishes Guidelines For Residency Programs

By D. Brent Mulgrew, JD, and Catherine C. Costello, JD

At its March meeting, the State Medical Board responded to a letter of inquiry from a hospital concerning the use of residents in a Family Practice program. In its answer, the Board addressed several issues common to all residency programs, such as the authority to write prescriptions, the supervision necessary for a resident, and the proper method of identifying residents. The Board's response contained the following guidelines:

1. Prescriptions
   A. Residents who do not hold temporary certificates shall not prescribe, administer, or dispense controlled substances in any setting. Residents who do not hold temporary certificates may prescribe, administer, or dispense non-controlled substances only within the guidelines of the residency program. Supervision shall be established according to Item #4 below.
   B. Residents who do hold temporary certificates may prescribe, administer, or dispense controlled or non-controlled substances within the guidelines of the residency program and under the supervision described in Item #4 below.
2. Identification of Residents
   A. The name tag and photo identification cards described in your letter (i.e., picture IDs which identify the person as a resident) are satisfactory identifiers. However, identification of residents who do not hold temporary certificates due to ineligibility because they are graduates of unapproved medical schools is a problem you will have to resolve internally. At a minimum, such residents should be identified as outlined.
   B. The method of notice to new patients that they will be seen by a resident is acceptable (i.e., for an initial appointment, written notice is given to the patient that a resident is in attendance). Further, the patient should be informed that a licensed preceptor physician will supervise the resident's management of the patient.
3. Appointment Procedure for Outpatients
   A. The appointment procedure outlined in your letter is acceptable (i.e., the appointment clerks will advise all first time appointments by phone that they will be seen by a physician resident or physician-in-training assigned to their first appointment. The patient will not be permitted to make an appointment with a particular resident UNLESS the patient has previously been seen by that resident. The Program Director will determine how resident assignments are made.)
4. Supervision of all residents in the Family Practice Residency Program
   A. Trainees holding temporary certificates are required by Ohio Revised Code Section 4731.291(A)(3) to practice only under the supervision of the attending medical staff of the hospital. The same requirement of supervision applies to trainees in residency, internship or fellowship programs who do not hold a temporary certificate. This requirement, however, does not necessitate the physical presence of a fully licensed physician at all times while a resident is examining or treating patients. The physician should be present at the clinic though. It is important, however, that the patient care duties delegated to residents be commensurate with their level of training and experience. It is also important that the residency program be structured to provide review by the attending physician or other fully licensed physicians of the care given by the residents. See Item #4B. In certain types of cases, both the attending physician and resident may need to personally examine or treat the patients jointly.
   B. Chart entries and all prescriptions written by *any*

The OSMA is registered as a 501 (c)(6) corporation with the Internal Revenue Service. To maintain such standing, the Association's activities must promote the common interest of the membership rather than provide specialized services to individuals. Consequently, this column will be devoted to general legal questions of interest to the membership. Suggestions for future columns may be sent to: OSMA Department of Legal Affairs.

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resident shall be reviewed by a licensed preceptor physician prior to the patient leaving the clinic.

C. In any event, when a patient has not actually been seen and personally attended by the licensed physician, no physician's professional fee shall be charged.

Sidney Peerless, MD Fills Board Vacancy

The Ohio State Medical Association (OSMA) wishes to congratulate Sidney A. Peerless, MD, Cincinnati, for his appointment as a member of the Ohio State Medical Board.

Dr. Peerless fills a vacancy created by retiring board member Oscar W. Clarke, MD, Gallipolis. He will serve on the board for five years from March, 1984 to March, 1989.

A graduate of the University of Cincinnati College of Medicine and Harvard Post Graduate School, Dr. Peerless is a specialist in otolaryngology and maxillofacial plastic reconstruction. He is Board Certified by both the American Board of Otolaryngology and the American Board of Cosmetic Plastic Surgery.

Dr. Peerless is an Assistant Clinical Professor in the Department of Otolaryngology and Maxillofacial Surgery at the University of Cincinnati, and Chief of the Otolaryngology and Maxillofacial Surgery Departments of both Providence Hospital and Jewish Hospital. He also served as President of the Medical Staff of Jewish Hospital from 1975 to 1979.

The OSMA wishes to express its sincere appreciation to Dr. Clarke for his five years of dedicated service to the board, including his year as president in 1983. Dr. Clarke's commitment to medicine and his outstanding leadership have won him the admiration and respect of all Ohio physicians. **OSMA**

D. Brent Mulgrew, JD, and Catherine Costello, JD, are in OSMA's Department of Legal Services and serve as OSMA's Staff Counsel.

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Obituaries

GEORGE F. ALTER, MD, Redington Shores, Florida; Duke University School of Medicine, Durham, North Carolina, 1952; age 67; died March 7, 1984; member OSMA and AMA.

PETER BRDAR, MD, Cleveland; Case Western Reserve University School of Medicine, 1952; age 62; died February 15, 1984; member OSMA.

BENJAMIN S. BROWN, MD, Youngstown; Case Western Reserve University School of Medicine, 1942; age 69; died February 26, 1984; member of OSMA and AMA.

ROBERT BROWNING, MD, Berkeley, California; Case Western Reserve University School of Medicine, 1927; age 80, died February 15, 1984; member OSMA and AMA.

ADOLPH BUSHMAN, MD, Portsmouth; Latvijas Universitate Medicinas Fakultate, Riga, Latvia, 1938; age 70; died February 27, 1984; member OSMA and AMA.

THEODORE CUTRIGHT, MD, Bainbridge; Ohio State University College of Medicine, 1932; age 81; died February 7, 1984; member OSMA and AMA.

FREDERICK GRANT, MD, Akron; University of Rochester School of Medicine, Rochester, New York, 1940; age 69; died February 18, 1984; member OSMA and AMA.

EMERSON HATCHER, MD, Columbus; Cornell University Medical College, New York, New York, 1938; age 71; died February 21, 1984; member OSMA and AMA.

GEORGE A. HOKE, MD, Lorain; Case Western Reserve University School of Medicine, 1947; age 85; died February 3, 1984; member OSMA.

JOHN E. IMBODY, MD, Marion; Case Western Reserve University School of Medicine, 1945; age 63; died February 6, 1984; member OSMA and AMA.

ROBERT W. JONES, MD, Mansfield; Temple University School of Medicine, Philadelphia, Pennsylvania, 1951; age 59; died February 26, 1984; member OSMA and AMA.

STANLEY LUNAS, MD, Elyria; Medizinische Fakultat der Universitat Hamburg, Hamburg, Germany, 1955; age 63; died March 3, 1984; member OSMA and AMA.

FREDERICK MAUTZ, MD, Chardon; Case Western Reserve School of Medicine, 1933; age 76; died February 3, 1984; member OSMA and AMA.

HARRY MENDELSOHN, MD, Cincinnati; University of Cincinnati College of Medicine, 1937; age 73; died February 7, 1984; member OSMA.

KENNETH L. MEYERS, MD, Dayton; Loma Linda University School of Medicine, Los Angeles, California, 1938; age 70; died January 10, 1984; member OSMA and AMA.

HARRY NIEMAN, MD, Dayton; Ohio State University College of Medicine, 1936; age 74; died January 10, 1984; member OSMA and AMA.

KARLIS N. POPE, MD, Andover; Latvijas Universitate Medicinas Fakultate, Riga, Latvia, 1926; age 86; died February 28, 1984; member OSMA and AMA.

WILLIAM ROASBERRY, MD, Shelby; Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania, 1942; age 68; died February 25, 1984; member OSMA and AMA.

FRED J. SCHUSTER, MD, Cleveland; University of Michigan Medical School, Ann Arbor, Michigan, 1920; age 89; died January 29, 1984; member OSMA and AMA.

PHILIP D. WEEMS, MD, Portsmouth; University of Tennessee College of Medicine, Memphis, Tennessee, 1931; age 76; died March 15, 1984; member OSMA and AMA.

ROBERT F. WILLIAMS, MD, Cleveland; Case Western Reserve University School of Medicine, 1943; age 65; died February 22, 1984; member OSMA and AMA.

Cardiology costs lower in HMOs

Cardiologists in health maintenance organizations (HMOs) tend to be more conservative in ordering costly diagnostic and therapeutic procedures than cardiologists in a community or university practice setting, according to a University of California, San Francisco study. The differences may partially account for the lower health care costs found in HMOs, the authors say.

Writing in the October 1983 issue of **Archives of Internal Medicine**, researchers report that HMO cardiologists who reviewed histories of patients with chest pain and suspected coronary artery disease recommended an exercise thallium scan — a $600 procedure — in 47% of cases. This compares with 72% for university physicians and 67% for community physicians who reviewed the same patient histories.

When asked to rate the need for coronary angiography, which can cost about $3,000, the HMO cardiologists tended to think this procedure was indicated less often than physicians in the community and university settings.

Although all three groups of physicians were comparable in recommending coronary bypass surgery for patients with disease in three arteries, differences among the practice settings appeared with patients having lesions in only one or two arteries. Twenty-two percent of HMO cardiologists recommended surgery for these patients, compared with 35% of the university physicians and 53% of the community-based physicians.

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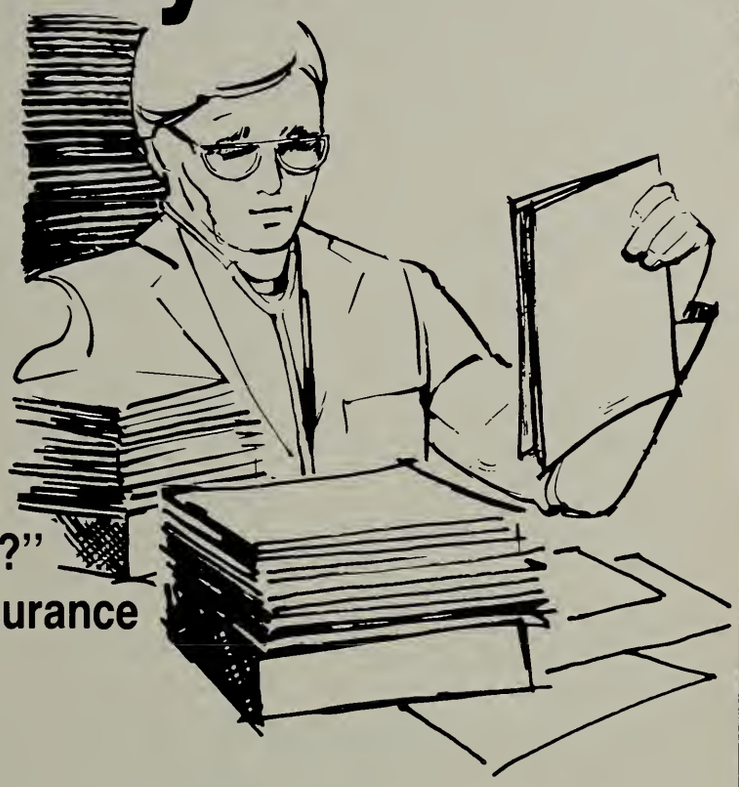
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CLINICAL NOTES

Edited by Karen S. Edwards

Suicide Pacts

There is a tendency to believe that a suicide pact is a situation in which two people mutually agree to act, but interviews with survivors indicate that pressure was used by the instigator to convince the partner to comply. This finding suggests a homicidal component in suicide pacts, according to the author. Since instigators in suicide pacts between couples are more likely to be male partners who are severely depressed, physicians should evaluate their depressed male patients for "murder risk" as well as "suicide risk," Rosenbaum advises.

— *Archives of General Psychiatry*

Drug Interactions May Complicate Flu Shots in Elderly

Elderly patients who take drugs metabolized by the liver may be at risk for drug interactions following immunization for influenza. The authors advise vigilance when immunizing elderly patients who also receive drugs such as warfarin (an anticoagulant) and oxytriphlline (a bronchodilator). Interferon, which is produced in the body during an influenza infection, may be responsible for the interactions, the scientists say, so cancer patients of any age who receive both chemotherapy and interferon are also at risk from influenza immunization.

— *Journal of the American Medical Association*

"Early" Ovarian Cancer

Ovarian cancer, the most lethal gynecological malignancy in the United States, is often understaged when first diagnosed, resulting in inadequate treatment. Thirty-one of 100 patients with supposed "early" ovarian cancer staged by laparotomy were found to have more severe disease after examination with a second laparotomy as well as x-ray and direct visualization techniques, write physicians from the Mayo Clinic, Rochester, Minn.; M.D. Anderson Hospital, Houston; Roswell Park, Buffalo, N.Y.; and the Medicine Branch of the National Cancer Institute. Only 25% of patients, they add, have an initial surgical incision that is adequate to allow complete surgical examination of the areas that are at high risk for metastatic spread of ovarian cancer.

— *Journal of the American Medical Association*
December 10, 1983

D & E Proves To Be Safer Method of Abortion

Dilatation and evacuation (D & E) is a safer method of midtrimester abortion, say Michael E. Kafrissen, MD, MSPH, and colleagues from Atlanta's Centers for Disease Control. The researchers say they compared D & E with another method considered safer by some (intra-amniotic instillation of hyperosmolar urea and prostaglandin F 2a). The latter method resulted in significantly more serious complications than D & E (1.03 vs. 0.49 per 100 abortions). The advantage applies up to 16 weeks, after which the relative risks of the two methods are comparable, they say.

— **Journal of the American Medical Association**

AIDS: The Latest

Despite some family clusters of AIDS, no current data suggest that routine close contact in a family household can spread the disease horizontally.

Over 100 household contacts of AIDS patients, including siblings, were studied, including three families where more than one child with AIDS or its prodrome (indications of onset of disease) were detected. However, in those cases, the researcher suggests, the syndrome was transmitted not from child to child but from mother to child.

While the transmission of AIDS to infants is still speculative, researchers believe the syndrome may be transmitted from mother to child, either in utero or shortly after birth, because most of the women studied had a severe immunodeficiency detectable at the time of diagnosis of AIDS in their infants.

Here in Ohio, researchers at the University of Cincinnati suspect that AIDS, in some patients at least, might be related to components of semen that find their way into the blood stream and damage the body's natural defense mechanism. They are giving particular attention to one group of active components in semen, known as glycoproteins.

According to those researchers, glycoproteins exist in all healthy men. They are now looking to determine if they are also present in AIDS patients and, if so, if they are functioning normally. Their theory is that in some AIDS patients these components might be absorbed into the blood stream where they may be damaging the immune system.

American Journal of the Diseases for Children

One study, completed by University of Miami researchers, indicates that Haitians seem to have a depressed cell-mediated immunity which makes them more susceptible to AIDS than other populations. The researchers base their conclusion on a comparison of autopsy reports made on 63 Miami Haitians and a control group of native black Americans. The reports showed that twice as many Haitians had died from opportunistic infections than did patients in the control group. The researchers initiated their autopsy study in May 1981, after autopsies of Haitians revealed lesions of opportunistic diseases in previously healthy adults.

Journal of the American Medical Association

Cancer of the Head and Neck

By William Farrar, MD

INTRODUCTION

Cancer of the head and neck constitutes about 5% of the total new cancer cases in the United States. The American Cancer Society has estimated there will be 39,000 new cases in 1983. The male-to-female ratio is approximately 3-4:1. This ratio has not changed over the past three decades, although there has been a substantial increase in cigarette smoking in women. Cigarette smoking is a recognized carcinogen. Surgery and/or radiation therapy remains the primary treatment. The role of chemotherapy is yet to be defined.

EPIDEMIOLOGY

Chronic irritation in the pathogenesis of head and neck cancer was recognized by Hayes Martin and his contemporaries over 50 years ago. It is generally agreed that over 90% of such cancers arise in susceptible persons after exposure to one or more known environmental factors.

Sunlight is an established major cause of skin cancer and is directly responsible for a high percentage of lip cancer. Ninety-five percent of lip cancers occur on the more exposed lower lip. It is also well recognized that all forms of tobacco use increase the risk of lip cancer. Pipe smoking is thought to be more commonly associated than cigarette smoking because of the additional risk which may accrue from the chronic thermomechanical irritation caused by the pipe stem.

The triad of heavy tobacco use, alcohol use, and poor oral hygiene has been implicated in the etiology of oral cavity and pharyngeal cancer. There is no question concerning the role of tobacco. Although in this country, cigarette smoking is associated more closely with laryngeal and lung cancer, most people who develop oral cancer smoke. Only 3% of cancers in the United States are of the oral cavity, while they make up 50% in India. This difference reflects the use of tobacco. In India, where carcinoma of the hard palate is endemic, they practice reverse smoking, with the lit end held in the mouth. They also hold betel nut and pan (a combination of betel nuts, slaked lime, and tobacco) in the cheek while sleeping. There has been some recent evidence that heavy exposure to alcohol correlates more closely with oral, pharyngeal, and esophageal cancers than does cigarette smoking. The bottom line is that the mechanism of alcohol and tobacco cocarcinogenesis remains unsettled. There are data which show tobacco increases the chance of developing a head and neck cancer by 6%, alcohol by 6%, and both together by 15%. Many other factors have been implicated, such as chronic dental irritation, poor oral hygiene, viral infections, and others. None can be confirmed owing to the compounding effect of tobacco and alcohol. Cancers in other areas of the head and neck, larynx and hypopharynx also have a direct relationship with alcohol and tobacco.

In summary, the pathogenesis of 90% of squamous cell carcinoma of the head and neck is directly related to environmental risk factors. If one could refrain from alcohol and tobacco use, the chances of getting head and neck cancer would be negligible.

DIAGNOSIS

Accurate management of head and neck cancer begins with a complete head and neck examination. Unlike many other cancers, head and neck cancer is usually detected by physical examination, and correct diagnosis can be made in the office. A complete head and neck examination, which is seldom done, should include inspection and bimanual palpation of all anatomic areas of the neck, oral cavity, oral pharynx, etc. Indirect laryngoscopy should always be done to visualize all anatomic areas. Any lesion or area that appears abnormal should be biopsied. Local anesthetic is usually all that is needed for the examination of accessible lesions. An incisional biopsy including abnormal and normal tissue can be easily performed. Punch biopsy can be used to obtain a core of suspected malignant tissue from a mass covered by normal mucosa. Biopsy of lesions in more dangerous and inaccessible locations should be performed by a skilled head and neck surgeon, with the patient under general anesthesia. Neck masses can be evaluated by thin needle aspiration biopsy. X-rays and other specialized procedures are usually not required to establish the correct diagnosis in most head and neck cancers. C-T can be helpful in establishing the extent of disease for proper staging.

STAGING

Head and neck cancer should be

properly staged using the TNM system. Problems in using this system arise from variations in classification that cause occasional difficulty in measuring the primary tumor. The task force that established this system found it impossible to devise one primary tumor[T] classification that would be applicable to all head and neck tumors. In some regions, the diameter of the tumor was considered most important, while in other areas the direct extension or invasion of the tumor into adjacent sites was considered most important. The evaluation of the N and M status is more standardized. One example of TNM staging system for oral cancer is shown in Figure 1.

The choice of therapy many times is based on the stage of the tumor. If staged improperly, inappropriate treatment, either undertreatment or overtreatment, may be given. Proper staging is also important in evaluating the success or failure of treatment by comparing similar groups of patients.

TREATMENT

The choice of therapy for a patient with head and neck cancer is most influenced by the location and the stage of the primary tumor. Surgery and/or radiation therapy are the only potentially curative treatments for cancer of the head and neck. Chemotherapy, at present, must be considered experimental and should always be used only in conjunction with surgery or radiation therapy.

For early stage lesions, surgery alone or radiation therapy alone have yielded similar survival statistics. The choice of treatment then rests on such factors as general medical condition of the patient, the anticipated functional and cosmetic results, and, ultimately, the preference of the patient. Advantages of both treatment modalities are listed in Figure 2. For advanced stage lesions, combined surgery and radiation therapy is essential. The role of chemotherapy has still not been defined.

The results of surgery alone or radiation therapy alone in advanced head and neck cancer is far from satisfactory. It has been clearly shown that surgery removes the bulk of the cancer but fails to remove microscopic foci. Radiation has been very effective in removing subclinical foci of disease but cannot control bulky disease. Strong, from Memorial Hospital, prospectively evaluated the role of preoperative radiation therapy in the control of neck metastasis in squamous cell carcinoma of the head and neck. Preoperative bilateral radiation of the entire neck was given to 204 patients (2000 rads in five days), and 216 similar patients did not receive preoperative radiation therapy. Preoperative irradiation did significantly reduce the cervical recurrence rate from 37% to 24%; however, survival was similar in both groups.

In the 1970s, as more and more authors evaluated the role of combined radiation and surgery, there was a gradual shift away from preoperative and toward postoperative radiation therapy. Even though Marcial and associates from the Radiation Therapy Oncology Group showed that the morbidity in a randomized prospective trial of preoperative versus postoperative radiation therapy was essentially the same, most surgeons prefer postoperative radiation. Vikram and associates from Memorial Hospital compared the results of surgery alone to surgery plus postoperative radiation in a group of Stage III and IV head and neck cancers. Their data suggest an improvement in local control, especially if therapy is begun within six weeks of surgery. This will probably be found to improve long-term survival.

The role of chemotherapy in the treatment of head and neck carcinoma is presently being thoroughly studied. In earlier studies, methotrexate, with a 50% response rate, was considered the drug of choice. Although, 50% of tumors responded, chemotherapy did little to change the natural history of this disease. Recently, combination chemotherapy has effected dramatic regression in head and neck tumors. Spaulding and associates from the State University of New York at Buffalo recently reported 48 patients with advanced squamous cell caricinoma of the head and neck treated with combination chemotherapy: cis-platinum, vincristine, and bleomycin. The tumor clinically disappeared in 11 patients

FIGURE 1

TNM Staging System for Oral Squamous Cancer

Primary Tumor (T)
- T1 Greatest diameter of primary tumor less than 2 cm.
- T2 Greatest diameter of primary tumor 2 to 4 cm.
- T3 Greatest diameter of primary tumor more than 4 cm.
- T4 Massive tumor greater than 4 cm. with deep invasion to involve antrum, pterygoid muscles, root of tongue, or skin of neck.

Cervical Nodal Involvement (N)
- N1 Single clinically positive homolateral node less than 3 cm.
- N2a Single clinically positive homolateral node 3 to 6 cm.
- N2b Multiple clinically positive homolateral nodes, none over 6 cm. in diameter.
- N3a Clinically positive homolateral node(s), one over 6 cm.
- N3b Bilateral clinically positive nodes (each side staged separately).
- N3c Contralateral clinically positive node(s) only.

Distant Metastasis (M)
- MO No (known) distant metastasis.
- M1 Distant metastasis present.

FIGURE 2

SURGERY — ADVANTAGES
1. Limited amount of tissue exposed to treatment
2. Treatment time is short
3. Risk of immediate and late sequelae is avoided
4. Radiation reserved for subsequent head and neck primaries not suitable for surgery
5. Complete pathologic examination of tissue

RADIATION — ADVANTAGES
1. Avoidance of major surgery
2. Removal of no tissue
3. Elective radiation of neck nodes can be included
4. Surgical salvage of radiation failures is more likely than the salvage of a surgical failure

Continued

Cancer of the Head and Neck

continued

(22%). There was an overall response rate of 88%. Many other series have reported equal response rates. Most reports do not describe any excessive postoperative or short-term radiation complications following chemotherapy. The ultimate question — Does chemotherapy improve survival? — has yet to be answered.

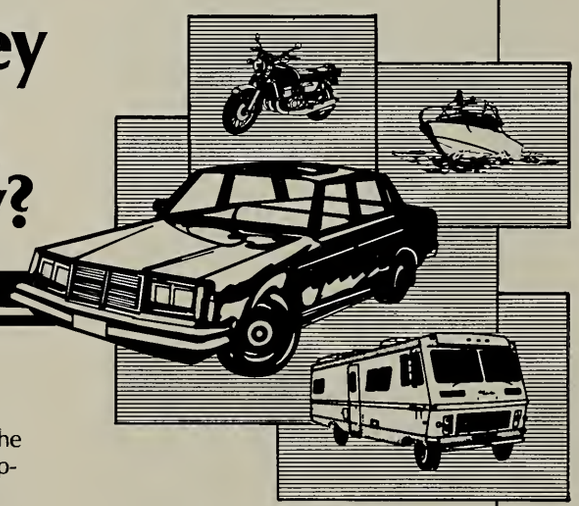
In summary, surgery or radiation therapy provide excellent control of early head and neck tumors. In advanced stage disease, surgery followed by radiation therapy provides the best local control. The value of added chemotherapy remains unknown. **OSMA**

William Farrar, MD, practices in Columbus.

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Making Advances

continued from page 345

the needs of the professional, as well as the patient and family, can be obtained by a phone call.

Many challenges still exist despite the fact that advances have been made. Ohio has been a leader in the fight against cancer in the past — and will continue to excel in this area. Within this issue of the **Ohio State Medical Journal,** Dr. Kellermeyer outlines precisely many of the areas of advance and the current treatments of choice.

We should be reminded that two of the three physicians who were involved in the initial chemotherapy of cancer patients are Ohio physicians: Robert Mercer, MD, of Cleveland, recently retired from the Cleveland Clinic Department of Pediatrics, and Robert Sylvester, MD, of Newark, an actively-practicing pediatrician.

To name all who have made contributions would be difficult. Suffice it to say that there are many today who are devoting their lives to this most worthwhile cause of cancer prevention and treatment.

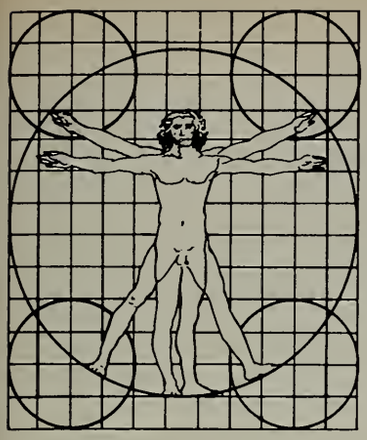
William A. Newton, Jr., MD, is Chairman of the OSMA Committee on Cancer.

New Test Screens SIDS

A new method for determining if an infant is prone to Sudden Infant Death Syndrome (SIDS) and is therefore in need of constant monitoring is now in use at St. Elizabeth Hospital Medical Center in Youngstown. Called the System 4000, the device screens a child's lungs and central nervous system for signs of breathing abnormalities which may lead to SIDS.

The tests involve feeding small doses of carbon dioxide to the infant through tubes inserted through the nostrils and then monitoring the child for reaction; babies at risk will not respond with the same increase in rate and depth of respiration as do normal infants.

If the test indicates abnormalities, the infant is placed on a heart and lung monitor until it reaches about six months of age — up until the time crib death is most likely to occur.



CLINICAL & SCIENTIFIC

RADIATION MYELOPATHY

George W. Paulson, MD*
Lowell R. Quenemoen, MD**

Ten cases of radiation myelopathy resulted from a therapeutic misadventure in which patients received excessive radiation. The myelopathy was manifested as paraparesis which was slowly progressive, or as a relatively nonprogressive form of myelopathy which presented with the Brown-Sequard syndrome. Steroids appear useful in fulminant forms of radiation myelopathy. The use of concomitant chemotherapy may accentuate the effects of radiation.

Introduction

Ten cases of radiation myelopathy resulted from a therapeutic misadventure in which at least 10% more radiation was received than was prescribed by the radiologist. As seen in these cases, the syndrome of chronic progressive radiation myelopathy may develop slowly and be incomplete, or in contrast may progress rapidly and lead to severe paraparesis. Chemotherapy combined with radiation therapy is probably more noxious than either modality used in isolation; eight of these 10 patients did receive chemotherapy.

Clinical Information

Numerous side effects of radiation of this misadventure were observed, including brachial plexitis, excessive skin reactions, and damage to the central nervous system or spinal cord. Ten patients had spinal cord damage secondary to radiation, no other cause being apparent and the excess exposure considered significant.

Seven of the 10 patients were female, three male, with ages from 45 to 72. Three patients had lung tumors, three patients had cancer of the endometrium, two patients had breast carcinoma, and one each had tumor of the larynx or tongue. Neurologic symptoms began one to 11 months after radiation therapy in all of the patients. Four patients with primary tumors of the breast or lung presented initially with a Brown-Sequard type syndrome, manifesting decreased pin prick and temperature in one leg and decreased strength in the other. All other patients developed paraparesis. All 10 cases had lumbar and cervical contrast myelography and no tumor was revealed. CSF protein and cells were normal in each. Basic myelin protein in the spinal fluid was elevated in two patients with progressive neurologic findings. Three other patients, all with nonprogressive or only slowly progressive course, did not have an elevation in the basic myelin protein in the CSF. EMG examinations in all 10 patients were nonspecific. Spinal evoked potentials were not performed in these patients.

The amount of excess radiation in each of the 10 patients was from at least 20% to 50% over the prescribed dosage of up to 5,000 rads, but the exact dosage is difficult to quantify since determinations were made retrospectively following discovery of the over radiation. The retrospectively estimated levels ranged from 5,500 rads to 8,750 rads. Possible added medical hazards in this group of patients included hypertension in two patients and diabetes in one. Eight of the patients received a full course of chemotherapy, all with more than one agent.

Discussion

It is well known that therapeutic radiation for cancer can lead to chronic progressive radiation myelopathy.[1-8] Major symptoms of such a myelopathy begin in the extremities, with both sensory and motor function disturbance. Weakness, along with complaints of paresthesias or burning, is the rule. One pattern is a partial Brown-Sequard syndrome with motor function more affected on one side and contralateral involvement of the sensation for pain and temperature. Vibration and position sense is often preserved in these cases. The second pattern, not a Brown-Sequard syndrome, consists of loss of touch and position sense associated with paraparesis or tetraparesis, and in these cases pain and temperature may also be affected. Classic signs of an upper motor neuron disease usually appear in the affected leg. All of our patients were injured by cervical or high thoracic radiation and a complex mixture of root, cord and plexus injury was present in some of the individuals. At least one case, not included in this group, appeared to have concomitant damage to muscles from the effect of radiation. The reflex pattern in this group of 10 patients included Babinski's and Hoffmann's signs and hyperactive deep tendon reflexes. Spasticity was common in both those four with the Brown-Sequard syndrome and in the more severe paraplegic syndrome.

An adequate diagnosis of radiation myelopathy[9] implies that: (1) the spinal cord was included in the area irradiated, (2) that the main neurologic lesion is within the area of radiation, (3) and that myelography or necropsy excludes cord compression or damage from metastasis.[10]

Prognosis in chronic radiation myelopathy is generally as-

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Submitted August, 1982

sumed to be very poor, but review of over 120 cases since 1960 suggests that at least two prognostic variants may be observed. The first course consists of a progressive syndrome with extremely poor prognosis; 75% of the patients in the literature fall into this category. Most of these patients (78%) were dead when reported, with an average survival of less than eight months. The majority of patients with such a poor prognosis manifest a clear-cut paraplegia, demonstrated by profound weakness of the legs and sensory level. With such progressive myelopathy, patients may deteriorate rapidly to an irreversible spastic paraplegia. The terminal event usually combines myelopathy, pneumonia, and inanition. In any of these cases of radiation myelopathy, the primary tumor can also be lethal but in many of the reported cases death was due primarily to the cord lesion.

In addition to the group with poor prognosis and progressive paraparesis, there is a second and less commonly recognized clinical course that is much less progressive and manifests a better prognosis. These patients may have the Brown-Sequard syndrome, some do have mild bilateral weakness or paraparesis. Approximately 25% of the cases in the literature fall into a more benign category. Three criteria suggest a more innocent course: (1) The neurological changes stabilize. (2) Minimum survival of at least 12 months. (3) The cord lesion is less than complete. In this group of patients, bladder and bowel problems are less common and secondary infections more readily handled than in patients with a progressive form of radiation myelopathy. As the outer limits of carefully controlled therapy are reached, it seems possible that more cases with less severe injuries may be seen.

The average survival of the patients with "benign" myelopathy is much longer than for those with inexorable progression; three-quarters of those with benign myelopathy are still alive at 42 months, as is true for four of our patients. Post radiation myelopathy may even have been associated with very successful treatment of cancer and, although small comfort from a medicolegal point of view, some of our patients may be alive because of the excess radiation. In the more benign group, myelopathy is not usually the cause of death. Physical therapy is feasible for the relatively benign cases with progressive changes and a few of our patients improved in mobility with therapy.

It is possible there are two subtypes of patients with chronic nonprogressive or "benign" radiation myelopathy. Some patients are seen to worsen progressively, but very, very slowly indeed. These patients have such chronic and insidiously progressive myelopathy and the survival is so long that their course is comparable to those with truly nonprogressive lesions. A second group with the benign case are those who clearly stabilize and then actually improve. A few patients have been reported in the literature since 1960 who fit into this category,[11] and at least two of our patients do seem to be improving five years after the insult.

Some of these efforts at categorization are forced, since there may be a continuum of effects whenever radiation myelopathy occurs. Detailed prognostication and clinical correlations are obviously desirable but difficult in practice. Local vascular changes, fibrosis, and differential neuronal susceptibility produce complex patterns that may be potentially anatomically understandable but are difficult to correlate with the clinical state.[12] Individuals will be seen who have local brachial plexus or muscle injury, or apparently isolated damage to motor neurons,[13] and in addition, the population suffers from metastasis, or has general or neuronal effects of chemotherapy. Another diagnostic possibility that may arise is the remote effects of cancer on the central nervous system.

For each case of presumed radiation myelopathy, the possibility of a locally treatable lesion must be eliminated. In addition, there should be an effort to identify subgroups among patients who do have myelopathy, both to assess therapy and for prognostication. The ultimate goal of therapy is to prevent, stabilize, or reverse the myelopathy for all groups. It would be useful to have predictive clinical and laboratory parameters which could distinguish relatively progressive and the relatively nonprogressive subgroups of patients who do have radiation myelopathy.

All of our patients have undergone electromyography and cerebrospinal fluid studies for evaluation of total protein and immunoelectrophoresis. Slow transferrin was noted with the immunoelectrophoresis, a nonspecific change that suggests degenerative processes. Cell count and total protein were not of value and the results of electromyography were nonspecific. Furthermore, electromyography did not correlate with progression and offered no predictive data. The course of radiation myelopathy cannot even be predicted on the basis of the results of myelography, since the spinal cord in such cases may be normal, swollen, or small. In rare instances when the cord is swollen, radiation myelopathy may simulate a tumor.[14]

Since demyelination is an accepted accompaniment of radiation myelitis, and since a measure of demyelination might have predictive value, a check of the myelin basic protein was performed for five patients. Basic myelin protein has been of interest in clinical neurology, since it can elicit an allergic encephalomyelitis and since basic myelin protein is not normally present free in the cerebrospinal fluid but can be present in cases with multiple sclerosis. Our patients with low levels of basic myelin protein were all in the nonprogressive classification, but there is an insufficient number of patients to determine if absolute values correlate with finer graduations of progression.

Potentially, the use of somatosensory evoked potentials might be of value as a predictive technique.[15]

The most obvious means of prediction is linkage with the dosage and fractions of radiation exposure, but such correlation is surprisingly difficult.[16] Individual vulnerability varies, with a few patients who receive only 3,000 rads reported to develop damage, whereas for others the commonly toxic dose of 6,000 rads produces limited harm. Abnormal blood vessels, preexisting hypertensive change,[17] placement of the beam, and the rapidity of the series of treatments can be relevant factors. Neuronal[18] or vascular proliferative changes[19,20] vary, depending upon age or other unknown factors.

In our case, due to the time variable, specific levels were difficult to ascertain and experts offered more than one alternative possible level. For the purpose of this article, we chose the lowest level suggested by any expert, and none of these patients had less than 20% overdose from the levels currently recommended in the literature. There is clearly greater risk of damage when dosage is greater, but exact epidemiology is often impossible in cases of radiation myelopathy. Despite community awareness of this misadventure, additional cases may have died of other causes before the effects of overdose were apparent.

The role of chemotherapy may be additive, as has been suggested.[21,22] We have the distinct impression that those patients with radiation overdose had more severe tissue injury when chemotherapy was utilized in close proximity to the radiation therapy. The literature and our data do not prove such a linkage. Fever may also potentiate the effects of radiation. There was no obvious effect of age, systemic illness, diabetes or hypertension in our patients.

Therapy for radiation myelopathy is difficult. The use of steroids appears logical, as in other conditions that produce acute demyelination. Also, as in other demyelinating conditions, the exact value of steroid therapy remains unproven. We used steroids for alternate-day therapy in all of these cases and had the distinct impression that steroids were helpful in slowing deterioration and relieving symptoms, including pain. Further symptomatic relief from pain was offered by carbamazepine for three patients and by a transcutaneous stimulator for one patient. Several patients received baclofen for spasticity, but this offered only modest benefit. Physical therapy provided encouragement for the family as well as education and psychological benefit for the patient.

Conclusion

Review of the literature and of our 10 cases suggests two

subdivisions of chronic radiation myelopathy. One, the milder form, represents a Brown-Sequard syndrome or there may be a paraplegic syndrome. There is a progressive form of the disease and also a relatively nonprogressive form. The relatively nonprogressive form may present as the Brown-Sequard syndrome which can be seen with more unilateral radiation. Concomitant chemotherapy probably accentuates the effects of radiation. Myelin basic protein may eventually be correlated with the clinical progression of radiation myelopathy, but results in our small series are inconclusive. Patients with negative values for myelin basic protein did fit into the apparent category of a nonprogressive myelopathy. Steroids may be used in cases with fulminant forms of radiation myelopathy; but benefit will be hard to prove in the sporadic and often partially concealed local epidemics of radiation myelopathy.

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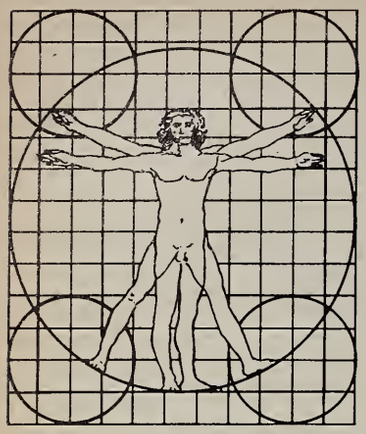
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CLINICAL & SCIENTIFIC

OHIO FAMILY PHYSICIANS: SURPLUS OR SHORTAGE?

Roland C. Griggs, MD

In the face of an impending physician glut, Ohio has increased medical school enrollments and family practice residency positions in the past decade. Yet, 29 Ohio counties were designated primary care shortage areas in 1981. This encourages the claim that there is insufficient physician manpower in smaller communities, due to maldistribution. Although no true assessment of primary care "supply" exists, Ohio Department of Health and independent surveys suggest that family physicians are locating in Ohio's less populated communities. The legislative gestalt to maximize physician production and rely on "filter down" distribution to Ohio's underserved areas is working, but expensive. For a more cost effective primary care manpower policy, Ohio could benefit from a system to accurately assess physician supply, continued support of family medicine, and private sector funding of medical education.

Introduction

GMENAC's prediction of nationwide physician surpluses by 1990 has been well publicized. Apparently contributing to this trend, Ohio has increased funding for new and existing medical school enrollments since 1970. Concurrently, Ohio's family practice residency positions have increased within the past five years. It seems appropriate measures have been taken to increase physician supply to meet the needs of the state's residents.

A hypothesis persists that "the number and distribution of doctors practicing in small- and medium-sized communities of Ohio is insufficient to meet future health care needs of the population."[1] Past efforts to verify this statement and to quantitate Ohio's primary care physician manpower include the work of Brown and Williams (1978, 1982) and Cooke (ODH, 1979).[2,3] Follow up data from these studies in conjunction with data from the Ohio Academy of Family Physicians (OAFP), American Academy of Family Physicians (AAFP), and The Ohio State University Department of Family Medicine suggest that Ohio family physicians (FPs) follow distributional patterns that increase primary care services in traditionally underserved geographic areas. The necessity for an accurate census of Ohio's FPs and the tieing of medical education subsidies to future service in underserved areas are emphasized as additional deterrants to maldistribution.

Method

Quantitation of Ohio's family physician (FP) manpower for 1980 is based on Brown and Williams' (1982) survey and unpublished data from The Ohio Department of Health (ODH).[4,5] Each source reached independent determinations of Ohio's total FP manpower in 1980, which were recorded and compared.

Identifying distribution patterns of Ohio's FPs between 1975 and 1980 was undertaken by comparing interim changes in each county's absolute number of FPs. The aforementioned sources provided 1980 figures, while their previous publications, using similar methods, furnished 1975 figures. Ohio counties showing increases in the absolute FP number between 1975 and 1980 were tabulated and arbitrarily divided into population categories of 50,000 and under and 100,000 and over. County population figures were based on Ohio Department of Economic and Community Development and preliminary Ohio census estimates.

Another approach to determine FP distribution patterns among less populated Ohio counties involves using U.S. Bureau of Health Professions' criteria, which considers a population to primary care physician ratio of 3,500:1, a shortage area.[6] Ohio counties fitting this definition, based on 1975 ODH statistics, were evaluated for absolute gains in FPs in 1980. Those noting increases were grouped into the above population categories and plotted on a map. The results were compared to figures for the same counties as determined by Brown and Williams (1978, 1982).

A third method for looking at distribution trends uses addresses of Ohio family practice residency graduates who elected to stay in Ohio between 1975 and 1980. These addresses, provided by the OAFP, were simply categorized into community population groups of under 15,000 and over 100,000.[7] Related data from The Ohio State University Department of Family Medicine and the AAFP were included for comparison.[8,9]

Results

ODH figures show that 2,990 FPs/GPs held state licenses in 1980. This is an increase of 537 physicians from the 2,453

Table 1
OHIO'S FP POPULATION: 1975, 1980

	1975	1980	Difference
ODH	2,453	2,990	+537
Brown and Williams	2,608.5	2,405.5	−230

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Submitted: December 1, 1982

GPs reported in 1975. Brown's and Williams's (1982) report 2,405.5 Ohio FPs in 1980, which represents a loss of 230 physicians from their 1975 number of 2,608. (See Table 1).

Brown and Williams' collective data reveal that 59% of Ohio counties experiencing an absolute increase in FPs had populations under 50,000, while 18% had populations over 100,000. ODH figures show that 50% of the counties which increased their FPs/GPs between 1975 and 1980 had populations under 50,000, and 25% were in the highest population category (See Table 2).

Table 2
POPULATION CHARACTERISTICS OF OHIO COUNTIES REALIZING AN ABSOLUTE INCREASE IN FP'S BETWEEN 1975 and 1980

Population	<50,000	>100,000
Brown and Williams	59%	18%
ODH	50%	25%

OAFP tabulations show that 47% of Ohio's family practice residency graduates between 1975 and 1980 chose to remain in Ohio communities with populations over 100,000. Thirty percent of these individuals chose less populated communities (under 15,000). The Ohio State University Department of Family Medicine figures for 1980 parallel those of the OAFP. An annual breakdown of each graduate class's community choice is represented in Table 3. Note that despite consistently lower percentages, the absolute number of graduates choosing less populated communities has annually increased.

The American Academy of Family Physicians (AAFP) has annually surveyed the country's family practice residency graduates for distribution patterns. Since 1975, despite changes in survey format and data analysis, roughly 40% per year of recent FP graduates have located in smaller communities.[9]

In 1975, ODH data showed 28 Ohio counties qualified as primary care shortage areas with physician-to-population ratios of 1:3,500. In 1980, an increase in actual FPs/GPs was documented in 14 of these counties, 78% of which had populations under 50,000, 14% in the 50,000 to 100,000 range, and 7% over 100,000. Brown and Williams' data differed by showing 42% (6/14) of counties with populations under 50,000 realized this increase in FPs/GPs.

Discussion

If a smaller Ohio community is interested in recruiting a family doctor, whom do they consult regarding physician manpower data for their area? The local Health Systems Agency (HSA) is a logical choice. A random telephone survey in August 1981 revealed that most HSAs utilized ODH statistics for local manpower planning policy. Only HSA III (West Central Ohio) undertakes an independent physician manpower survey. This is important, because a comprehensive alternative study of Ohio's FP manpower is the work of Brown and Williams (1979, 1982) whose results show significant discrepancies with ODH figures.

These discrepancies are best attributed to different methodologies which account for inflated ODH figures and Brown and Williams' underestimate for 1980. A high degree of compliance is assured for physicians to be relicensed and retabulated through the 1980 Standard License Renewal System (SRS), the ODH's data source. This contains all physicians licensed by the Ohio State Medical Board as of December 1980. However, all of these relicensed physicians may not be active or practicing in Ohio (e.g., multiple licensure).[11] In contrast, Brown and Williams rely on the efforts and abilities of key contact individuals to update a master list of practicing FPs in each county. Less accuracy in counties with large FP populations is a realistic expectation. This method also includes an age/retirement parameter for FPs over age 65 which deletes or counts them as 0.5 working unit. The authors acknowledge that 49% of FPs predicted to be retired in 1980 actually were.[12] These technicalities account for much of the difference between an ODH inflated estimate and Brown and Williams' underestimate of Ohio's 1980 FP manpower.

Although both sources include several facets of supply, they actually only estimate Ohio's FP population. An analysis of true FP supply requires consideration of such parameters as location, accessibility, availability, and productivity.[13] Brown and Williams may more accurately assess practice location with their personalized method. The ODH uses physicians' mailing addresses, which do not necessarily represent county of practice. Brown and Williams include an implied relationship between the age and productivity, but consideration of patient care hours, practice type, or other aspects of productivity are addressed by neither study. It follows that these estimates of Ohio's FP manpower cannot be translated into a true supply analysis. However, until a more comprehensive system to quantitate FP supply is developed, those determinations must be extrapolated from currently available FP census estimates. This data should be used in manpower planning with consideration of its inherent limitations as outlined above.

Despite discrepancies, both ODH and Brown and Williams' data suggest that less populated Ohio counties realized absolute increases in FPs between 1975 and 1980. This does not imply an increased supply as discussed above, nor does it account for any annual flux in each county's FP population. This trend is supported by OAFP residency figures which show rising numbers of new FPs choosing communities with populations under 15,000. Furthermore, AAFP residency graduate surveys have consistently reported movement toward smaller towns since 1975. Ohio appears to be increasing the number of FPs located in more sparsely populated areas. Whether this is due to market forces of increased supply "filtering down" to small communities with higher demand and less competition, the nature of the specialty to locate in smaller towns, or preference for more rural lifestyle is unknown.[14,15]

Although this paper's method of categorizing Ohio counties into shortage areas is not identical to official designations, 17 such counties met the criteria in 1980. These show a clustering in Southeastern Ohio. As of November 20, 1981, 29 entire counties and 17 partial counties were officially designated as primary care shortage areas.[11] Clearly, deficits in Ohio's primary care manpower and the subset of FPs persist.

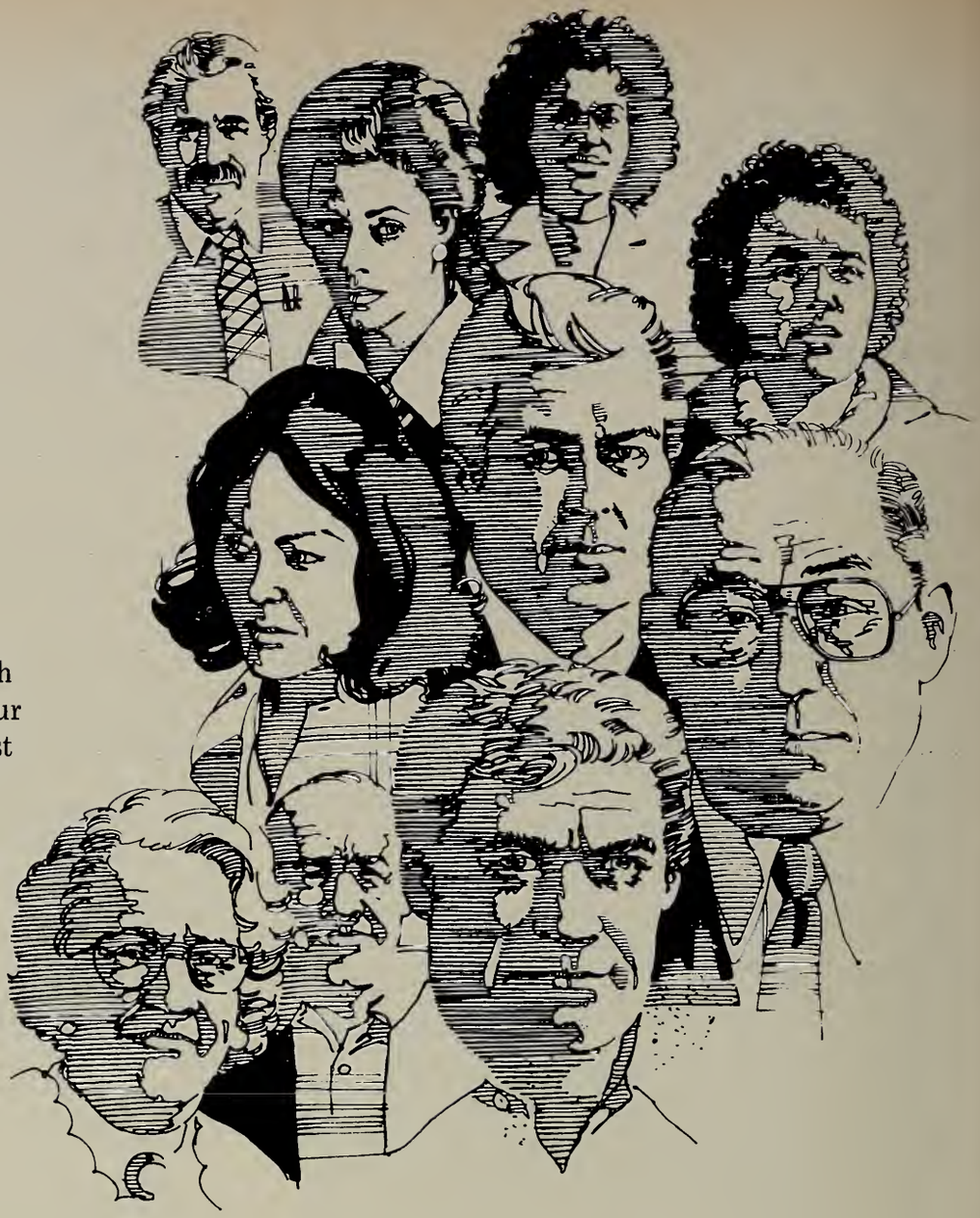
The dichotomy between public warnings of physician surpluses and Ohio's occult shortage areas should be clarified for health planners and government policy makers. This is especially relevant in light of the discrepancies between the best surveys of Ohio's total FP manpower. A system to accurately quantitate physicians and collect data on productivity, accessibility, and mobility, is needed to correctly assess supply. This system could be linked to the Ohio State Medical Board's licensure system, cross referenced with medical association membership data, specialty board certification, and perhaps checked by contact individuals in local communities. This information would improve the accuracy of supply determinations, the designation of shortage areas, and the design of future manpower policy.

Table 3
OHIO COMMUNITY CHOICES OF OHIO FAMILY PRACTICE RESIDENCY GRADUATES

	Community Population	
Graduation Year	100,000	15,000
1976	54% (14/26)	27% (7/26)
1977	36% (10/28)	21% (6/28)
1978	53% (17/32)	25% (8/32)
1979	50% (21/42)	40% (17/42)
1980	43% (26/60)	32% (19/60)
1980 (OSU Data)	50% (31/62)	31% (19/62)
TOTAL	47% (88/188)	30% (57/188)

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Despite persistent shortage areas, FPs seem to be locating in Ohio's more sparsely populated communities since 1975. This lends support to GMENAC's recommendation that:

> Given the geographic distributional patterns of family practitioners, graduate medical education programs in family medicine should continue to be supported as a strategy to increase primary care services in certain geographic areas of underservice.[16]

Hemenway notes that "the placement of medical schools and selection criteria for medical applicants can modify the geographic distribution of physicians, and so, too, can the tieing of students' subsidies to future work in underserved areas."[17] The former aspect of this statement resembles Ohio's past political gestalt for improving the physician manpower picture. Programs that find private funding for medical students in return for future service in shortage areas are supported by Hemenway's later statement. These programs have a place in Ohio's physician manpower policy, especially with dwindling federal subsidies for medical education. Matching future physicians with designated or perceived manpower shortage areas must be more cost effective than the expense of maximizing Ohio's physician production and relying on "filter down" distribution. Although Ohio's present policy seems to work, continued support for family medicine and encouraging private sector involvement in financing medical education should be included in Ohio's future manpower planning.

Summary

Ohio has legislated maximal physician production in the past decade to meet the state's manpower needs by a "filter down" process. Most available data documents only a physician census and includes few productivity, accessibility, or other parameters that assess supply. Nevertheless, current supply estimates are extrapolated from census data. A system to more accurately determine true physician supply is needed before the issue of maldistribution can be addressed.

Data presented here suggests many Ohio communities have a shortage of primary care and family physicians based on census alone. Since Ohio FPs seem to distribute in underserved areas, continued support for this specialty is indicated. An additional cost effective measure to alleviate maldistribution is to encourage programs that provide private monies for medical students in return for future service in perceived manpower shortage areas. While Ohio may have produced an expensive physician surplus, whether these numbers will "filter down" to practice as an "oversupply" of FPs in the state's underserved areas is yet to be determined.

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Report Shows Americans Today Are Healthier Than Ever

Contrary to the popular belief that modern-day lifestyles are hazardous to your health, a report issued recently by the American Council on Science and Health (ACSH) indicates that Americans today live longer and healthier lives than ever before. The reasons: dramatically improved health care, resulting from modern-day advances in science and technology.

For instance, the death rate from infectious diseases has plummeted to record lows in this century. An American born today can expect to live an average of 27 years longer than someone born in 1900.

Also, the death rates from heart disease and stroke, the first and third leading causes of death in this century, have declined significantly over the past 30 years. Even the age-adjusted death rates for most forms of cancer, the second-leading cause of death, have been declining gradually since the 1930s, the report says.

"Much of the American public believes, incorrectly, that our health has never been worse and that poor dietary habits and exposure to manmade products, such as food additives, pesticides and pollutants are to blame," says the executive director of ACSH. "The statistics prove this belief wrong. Modern technology and lifestyle have drastically reduced the health hazards to which we are exposed, rather than increasing them."

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INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

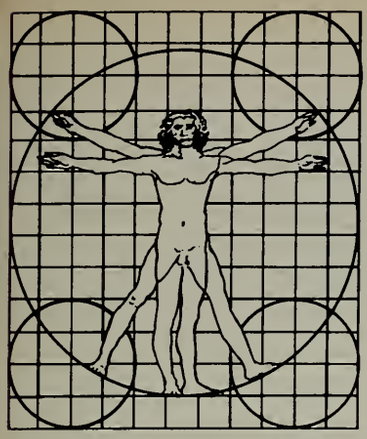
HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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MATERNAL PKU — A PROBLEM BORN OF SUCCESS

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Some two decades ago, Ohio and a number of other states launched a remarkably successful public health program to detect and combat the ravages of untreated phenylketonuria (PKU). Paradoxically, that success has created a new health problem; for lack of a better term the problem is labeled Maternal PKU. This article reviews the present state of the art in diagnosis and treatment of PKU and charts a public health course for women with successfully treated PKU to follow before they consider bearing children.

PKU IS AN AUTOSOMAL recessive metabolic disorder. The affected individual is unable to convert the amino acid phenylalanine to tyrosine due to a defect in, or absence of, the liver enzyme phenylalanine hydroxylase.[1] Untreated classical PKU patients have very high levels of phenylalanine and its metabolites in blood, urine, and other body fluids. The accumulation of these materials leads to moderate to profound mental retardation and neurological, behavioral and other clinical symptoms. These irreversible effects can be avoided through detection of PKU shortly after birth and prompt initiation of long term dietary therapy.[2]

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Since its discovery by Fölling in 1934,[3] variant forms of hyperphenylalaninemias (HPA) have been described. In contrast to classical PKU, most individuals with HPA variants have a limited but appreciable ability to convert phenylalanine to tyrosine.[4] When phenylalanine levels in most variant forms are below 15 mg%,[5] diet therapy is usually not indicated, as children with these levels generally have neither mental disability nor other clinical problems.[6,7]

The PKU diet utilizes special formulas low in phenylalanine to maintain blood levels between 2-10 mg%, an amount necessary to insure normal growth and development.[8,9] Additional essential amino acids are provided by other foods naturally low in phenylalanine. Lofenalac and/or Phenylfree, two formulas used in the management of PKU, are currently provided by the Ohio Department of Health, Division of Maternal and Child Health, to families free of charge for as long as the diet is maintained. The National Collaborative Study of Children Treated for Phenylketonuria presently recommends continuation of the diet beyond the previously recommended six years of age.[10] Even though the brain has achieved over 90% of its maximum growth, termination of the diet can lead to complications varying from decreased attention span and behavioral disorders to severe cerebellar ataxia and drop in intellectual functioning.[5,11]

Development by Guthrie of the bacterial inhibition assay[12] permitted the implementation of widespread screening of newborns for PKU during the first few days of life. A blood phenylalanine level on the screening test equal to or greater than 4 mg% dictates the need for diagnostic evaluation; the Guthrie test itself remains a screening test only. In Ohio, the State Legislature mandated that all newborns be screened for PKU in 1965; the law was implemented the following year. Since its inception, approximately 2.75 million infants have been screened for PKU with positive diagnosis in 191 children, an incidence rate of approximately 1:14,400.

Because of effective preventive treatment initiated almost 20 years ago, children who would otherwise have been significantly retarded have become normally functioning young adults of reproductive age. First described by Dent in 1957, Maternal PKU has been noted nationwide with increasing frequency. Dent reported three children of a mother with PKU who without having PKU themselves were severely mentally retarded.[13] Since Dent's report, other investigators have described microcephaly, congenital heart disease, intrauterine growth retardation, and

mental retardation among offspring of mothers with PKU.[14,15,16] Up to 95% of children born to mothers with phenylalanine levels above 20 mg% will be born mentally retarded.[17] Maternal PKU also appears to increase the rate of spontaneous abortion.[12,14]

Until the mid-1970s, most PKU women of childbearing age were mentally retarded and few conceived. However, routine newborn screening and early treatment of children with PKU during the last 17 years have resulted in a generation of young women with PKU who have normal intelligence and the usual expectations of becoming mothers.[18] Given average reproductive rates, the frequency of PKU related mental retardation could escalate to its former level after a single generation if genetic counseling is not available or used and if no treatment is available to protect the unborn children of women with PKU who elect to conceive.[19] Additionally, women with HPA are at risk.[17]

Attempts have been made to improve the outcome of pregnancy by diet manipulation. To date, such efforts have had limited success; normal appearing infants have been born only to HPA women whose phenylalanine levels were low even prior to dietary treatment. However, most of the women who have been treated were placed on the diet post-conception, often after the third month of pregnancy. Improved management through collaboration with experts in the treatment of PKU and high-risk obstetrics and institution of the diet prior to conception might increase the likelihood of a positive outcome.[20] Such services are available in Ohio through six state-supported high-risk perinatal centers in Cleveland, Columbus, Cincinnati, Dayton, Akron and Toledo, and Genetic Centers in Cincinnati, Cleveland, Columbus, Akron, Dayton, Toledo and Youngstown. Although exact amino acid, vitamin and mineral requirements have not been precisely defined, recommendations for the dietary management of Maternal PKU have been made.[21] In addition to dietary manipulation, the management of the pregnancy would optimally include ultrasound studies: serial measurements of fetal growth and examination for the presence or absence of congenital malformations and congenital heart disease.[22]

Dietary treatment should be instituted *prior to conception.* This underscores the importance of reaching all young women known to have PKU or HPA, so that they may receive proper treatment including counseling about the possible consequences of pregnancy, recommended dietary changes to be started preconceptually, the possibility of a poor outcome even with good dietary control, and the full range of alternatives to pregnancy. Although many of these women are followed by Genetics Centers in the State, additional efforts need to be made to identify and locate young women who were treated during childhood but have since been lost to follow-up.

If you know or presently serve any such women or wish further information regarding the State Perinatal or Genetic Centers, please contact the Ohio Department of Health Genetics Program in the Bureau of Maternal and Child Health (Box 118, 246 North High Street, Columbus, Ohio 43216).

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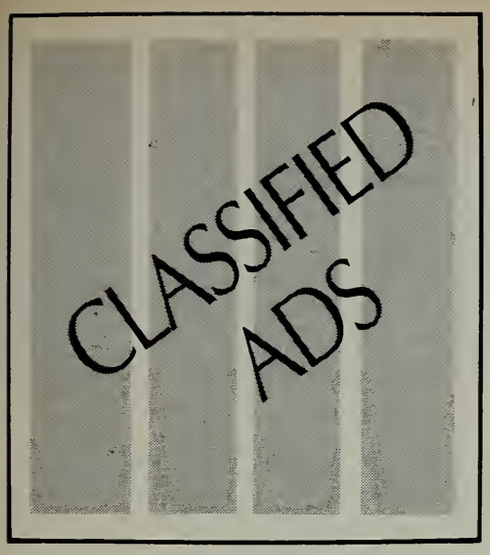
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1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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Bactrim is indicated for the treatment of recurrent urinary tract infections due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii*. However, it is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single antimicrobial agent rather than the combination.

Maintain adequate fluid intake during therapy. Bactrim is contraindicated in pregnancy at term, during lactation, in infants under two months of age and in documented megaloblastic anemia due to folate deficiency.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

B.I.D. for enhanced compliance.

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Please see summary of product information on the following page.

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Wormser GP, Keusch GT, Heel RC: *Drugs 24*:459-518, Dec 1982. 3. Ronald AR: *Clin Ther 3*:176-189, 1980. 4. Rubin RH, Swartz MN: *N Engl J Med 303*:426-432, Aug 21, 1980. 5. Cunha BA: *Postgrad Med 70*(6):149-156, Dec 1981. 6. Neu HC: *Infectious Diseases 10*(6):4, 19, Jun 1980. 7. Jones SR: *Ration Drug Ther 13*(11): 1-5, Nov 1979.

BACTRIM™ (trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1983 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

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Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

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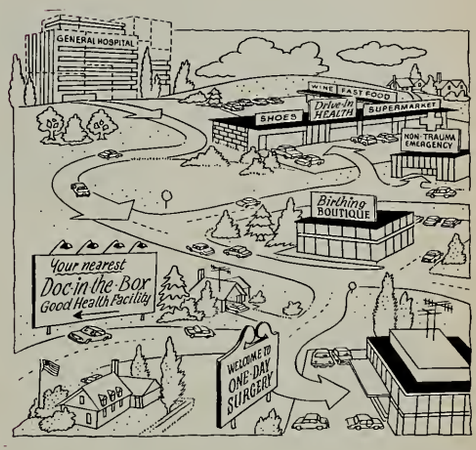
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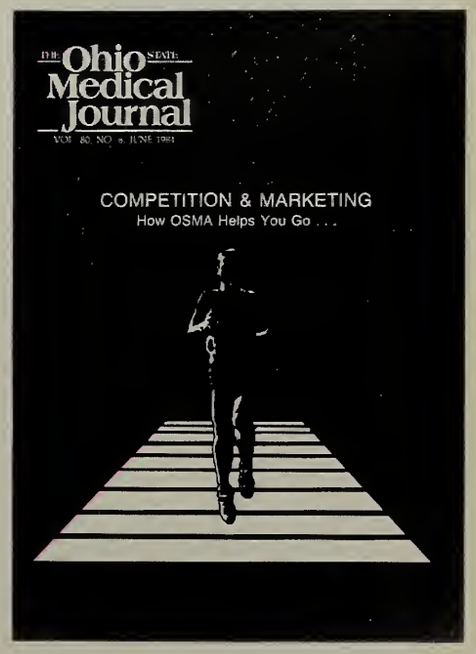
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A. Burton Payne, MD
President

The Responsibility of Unity

By A. Burton Payne, MD

This is my first President's Page. As President of the Ohio State Medical Association, I represent you, the members of the Association. Representing you to the public is an exciting task and I look forward to it. Speaking on the issues facing all of us is my primary responsibility. Yours is the real voice of medicine — without active support, my voice will echo hollow.

I am an anesthesiologist. I practice in Ironton, Ohio. Even though the federal government Prospective Payment System programs say my hospital is an "urban facility," most individuals view my practice area as rural Ohio. I understand the medical needs of rural Ohio. First and foremost, I am a physician. We all must remember that first and foremost, we are physicians. No matter what our specialty, the fact that we are physicians sets us apart from other "health care practitioners."

In Ohio, a medical doctor or doctor of osteopathic medicine has an unlimited right to practice medicine. Your license to practice medicine is not qualified. The definition of the practice of medicine is broad. Other individuals would like to perform acts which you and I consider to be the practice of medicine. Other groups believe that so long as they only "diagnose" and do not "treat," they are not practicing medicine. Others argue that so long as they only "treat limited areas," they are not practicing medicine. Still others argue that the proper physician's role is the tertiary level or final level, after prior screening by individuals with different training. Still others believe that once a diagnosis has been made by a physician, they should be able to treat.

The legislative arena is not the only area in which physicians are being challenged. The issue of health care costs is driving a wedge between the specialists of our profession. During the next year, prospective payment and DRGs will set individual physicians against their medical staffs, medical staffs against their hospital administrators, and individual practitioners against each other, as cost-shifting and responsibility-shifting for costs occur. It is essential that we don't let our individual economic or practice interests divide us as we face the issue of health care costs. Collectively, we can confront those who wish to radically change the finest health care system in the world. Individually, our objections will be ignored. Your specialty, your practice relationship with your hospital and your relations with your peers are critical factors in *our* collective "effectiveness." I hope I can be assured of the continuing support of all specialties in organized medicine. I hope all of you will support me as I try to speak for you.

The first step toward unity is active commitment and participation. Active participation in OSMA as well as your county medical society and hospital medical staff are all necessary. Your participation in organized medicine is as important to your practice and your future as the care you give your patients. As a past chairman of Ohio Medical Political Action Committee, I can think of no better way to express your commitment to the future of organized medicine than joining and participating actively in the OSMA and then by joining OMPAC as a sustaining member. The OMPAC is *your* PAC. OMPAC does not lobby nor can it assure legislative votes once legislators are elected. What OMPAC can do is give campaign support to candidates who have in the past listened, and will listen to the positions of organized medicine in the future. Your participation in OMPAC gives *you* the ability to support medicine's friends and oppose its enemies in the legislative battles to come.

I hope all of you, no matter what your specialty, will join me in working for the betterment of medicine in this country. The issues are many, the problems immense. But if you don't enter the discussion and join the battle, all will be lost. **OSMA.**

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J-4044 January 1984

FACING THE COMPETITION

As health care continues to evolve, competition in the medical field is becoming more and more fierce. The proliferation of HMOs, and urgent care centers was just the beginning. Now, PPOs, IPAs, ambulatory surgicenters, and a whole new collection of medical oddities are offering patients — your patients — a whole new world of choices. Suddenly, the patient is a consumer, and you, the physician, are being squeezed into a position where you, too, must market your practice and compete for business.

This issue of the *Journal* explores the recent phenomenon of competition and marketing in the medical arena, and takes a look at what *you* can do to go that extra mile with your patients.

Since we have already entered an age of contractual medicine, our lead article examines this particular new hybrid indepth, including things you will want to know before putting your *own* name on a contract. The article, too, takes a look at some of the advantages and disadvantages of working under a contractual arrangement.

But what if you decide to forego the HMO-route, and open up a brand new private practice? How are you going to compete with the HMO down the street? Possibly by locating your office elsewhere — and one of our articles discusses the question of how to locate, or relocate, your office to your best competitive advantage. It is a situation that the Ohio State Medical Association (OSMA), and its offspring company, Physicians Administrative Corporation of Ohio, already have well in hand.

A whole new world of medical care choices is opening up. Suddenly, the patient is a consumer, and you, the physician, are being squeezed into a position where you, too, must market your practice and compete for business.

We take a look, too, at advertising — the messages that are being delivered by health care professionals not only here in Ohio but across the country. What's legal, what's ethical, what's practical? That's what our article is all about.

Finally, we examine the future of marketing in medicine. What new type of competition lies out there on the horizon, and what does it mean to you?

The OSMA's Department of Communications has already launched a program, aimed not only at making you more aware of the competition, but of the need to go one step further — that Extra Mile — in your own practice. And we give you suggestions on how to do that.

In this issue, we also: discuss the creation of the new hospital medical staff section which emerged last month at Annual Meeting; introduce you to the new medical student officers; and, in another article, we probe the account of a former impaired physician (an OSMA member) who has taken the story of his addiction and subsequent cure and gone public (that's marketing in an entirely different sense).

So read the issue and think about what it says. But don't take too long to act — to go that Extra Mile with your patients. After all, you never know, anymore, *what* kind of competition you'll be faced with tomorrow.

— *Karen S. Edwards*

Letters to the editor

Where Does Fiscal Responsibility Lie?

To the Editor:

With all the outcry of the need to control medical costs (expenditures) in the United States, I feel that we might do well to place those expenditures in perspective to other areas of spending in the United States. For instance, in the paper recently, an article on taxes broke down the average 8 hour work day as follows:

		Percent of Total
Federal Taxes	103 minutes	21.45
Housing Expenses	94 minutes	19.58
Food	64 minutes	13.33
State/Local Taxes	57 minutes	11.88
Personal Care/Savings	43 minutes	8.96
Transportation/Auto	42 minutes	8.75
Medical Care	36 minutes	7.50
Clothing	21 minutes	4.38
Recreation	20 minutes	4.17
	480 minutes	100.00

If this is indeed how we spend our earned income and *if* health care costs in total need a lid, why is it that there are no limits set on the housing industry by the government saying — we insist that you build $80,000 homes for our people on unemployment, welfare, or other government aid programs and that you accept $60,000 as payment in full for that home — and wait 3 to 6 months for your money — and then only after triplicate forms have been filed twice? WHAT WE DO IS PROVIDE GUARANTEED RENTAL INCOME and SPECIAL TAX INCENTIVES FOR ANYONE PROVIDING SUCH HOUSING! Why is it that there are no limts set on the food industry (other than milk) for what they charge — after all, we work twice as long to pay for our food as we do for medical care? WHAT WE DO IS TO PROVIDE FOOD STAMPS (with poor regulation) SO THE GROCER GETS *PAYMENT IN FULL* — and the holder gets cash in change. Granted the auto and transportation industries have numerous government regulations — why aren't we limiting how much General Motors or Chrysler Corporation is allowed to charge for their products — or the repair/maintenance of them? Oh yes, and let's have retroactive denial of payment for services because the sparkplugs are only to be replaced every 10,000 miles and you put them in after only 6,000 miles.

The grocer and the auto president would say — "but that would not be fair because we have costs beyond our control — materials, labor, overhead." The carpenter would say "I have a right to charge for my labor what the market will bear — and besides look how much doctors make." I would say to the former "I have those same expenses in running my office," and to the latter "If you are willing to work 60-80 hours per week and assume the responsibility of being available the other 80-100 hours in a week as many physicians do, you will be making as much as those doctors do."*

Last but obviously not least — when are we to expect our conscientious legislators to pass DRG restrictions on government spending? When do you suppose the Honorable Governor of Ohio, Celeste, will place a moritorium on housing construction as he has on medical facilities — after all every new house, every new apartment places an enormous additional burden on state and local government to maintain water, sewer, streets, police, schools and other community services. Are we to assume that the Governor wants us to follow his actions and increase our fees by 90% — with of course a promise to him and any other patient that we will refund a portion of our charges to them if we have any money left at the end of the year that we don't need? Or perhaps we should follow government's example and pay only 60% of our calculated tax (TEFRA Sec. 104) assuming that it will be accepted as payment in full?

Concerned about fiscal responsibility,

Jon E. Starr, MD

Columbus, Ohio

*Assume 70 hr work week with 50 hr time and a half + 15 hr double time pay ($17/hr x 40 hr) + ($25.50/hr x 15) + ($34/hr x 15) = $81,744.00/yr (NO on-call time included!)

Insurance Questions

Editor's Note: *The following letter was sent to the Director of Insurance, Mr. George Fabe. We reprint the letter, in its entirety, here.*

Dear Mr. Fabe:

As a resident and taxpayer in the State of Ohio, I am writing you as Director of the Insurance Department asking several questions that I would like you to answer. I am a practicing physician and a purchaser of professional liability insurance. I was alarmed by the recent article in the March issue of the *Ohio State Medical Journal* concerning the various companies that issue this coverage in Ohio.

My present insurance coverage is with the Physicians Insurance Company. Previously, it was with the State of Ohio JUA program and prior to that with Aetna Casualty. This article alludes to possible trouble with the current markets. As the overseer of this industry for the citizens of Ohio, I am asking you the following questions:

1. This article primarily concerns itself with two insurance companies, PIE and PICO. I feel that the weight of this article is reflected in the one paragraph which states that if PICO used the reserving system of PIE they could increase their surplus by 50% whereas if PIE used PICO's reserving system they could be technically bankrupt. How can the insurance department allow two companies to operate in opposite directions and justify the rates they are charging? Who is right and who is wrong; and how can you tell?

2. Being a specialty market, how can there be such a wide variety of rates between the carriers? I am informed that the great differential is in the companies excess premiums which are arranged by treaties by the various reinsurance companies. Are reinsurance companies governed by the same rules as all other companies — such as acturial studies to promulgate premiums? If not, why not?

3. My limited information tells me that the guarantee association will only protect me up to $300,000 if my company goes bankrupt and only for one year after that date. Should this be the fact, then what protection does this guarantee association give me for any claim that could be brought against me in event my professional liability carrier went bankrupt? From where I sit it sounds like I would not have coverage at all as if I did not purchase it in the first place.

4. How often does the insurance department review the financial structures of these types of companies and what are they looking for to make sure they are operating in a solvent manner, not only for today but for tomorrow? This article alludes to the reserving practice, which is a very important product of a professional liability carrier. What are your tests to indicate these companies (PIE & PICO) are reserving properly for tomorrows claim and are charging the proper rates?

The questions could go on and on but I believe that the important questions have been raised. I would appreciate an answer from you as I feel this is a very serious matter particularly in the light of what took place in Ohio in the mid '70s when we had our first malpractice crisis and lost many insurance markets.

Your consideration in these matters and your answer will be greatly appreciated.

Very truly yours,
Frederick T. Suppes, MD
Mayfield Heights, Ohio

Specialty Delegates Omitted, Not Ignored

To the Editor:

Please let me compliment you on your excellent articles and the excellent editing that have appeared in the *Ohio State Medical Journal.* I do have a question, however. In the April 19, 1984 Annual Meeting issue the Delegates and Alternates are listed from twelve districts, however, (and obviously it is because I am one of these,) the Delegates and Alternates to the OSMA House of Delegates from the various specialty societies are not listed. I wondered if this was an oversight or represented a not too subtle change in thinking on the part of the OSMA as it views the participation of the specialty societies in the House of Delegates?

Thank you very much for your consideration.

Sincerely,
Watson D. Parker, MD
Department of Physical Medicine and Rehabilitation
Wright State University
Dayton, Ohio

Editor's Note: *The omission was definitely an oversight. The OSMA feels strongly that the specialty society section is an important part of the House of Delegates, and views its participation as a vital part of organized medicine.*

It's Later Than You Think

To the Editor:

Just finished reading the article on "It's Later Than You Think" in the OSMA Journal.

I find it was done very well, and would like to commend you on a very clear, concise, and very effective article.

Sincerely,
Herbert G. Magenheim, MD
Cincinnati, Ohio

To the Editor:

I enjoyed your article entitled, "It's Later Than You Think" which appeared in the last issue (April) of **THE OHIO STATE MEDICAL JOURNAL.** Congratulations on your great work.

Sincerely,
Robert J. White, MD, PhD
Professor of Surgery, CWRU
Director of Neurosurgery, CMGH
Cleveland, Ohio

(The OSMA Journal *welcomes letters from its readers. Please address all letters to: Executive Editor, 600 S. High St., Columbus, Ohio 43215. Letters may be edited to meet space requirements.)*

Corrections

• In the article "Reflections on Ohio's Malpractice Climate," (*OSMA Journal,* April, 1984), the graph depicting Test 4 was titled "Two Year Overall Operating Ratio, 1981." The graph should have read "Two Year Adjusted Underwriting Ratio."

• The following new officers were elected (not appointed, March, 1984 OSMA Journal) at Massillon Community Hospital: **JAMES A. STANFORTH, MD,** president; **R. KENNETH LOEFFLER, MD,** president-elect; **RAHIS LABABIDI, MD,** secretary-treasurer; and **JOHN A. FRENZ,** member-at-large.



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The Coming Revolution in Health Financing

By Robert J. White, MD

Are you getting fatigued reading all of those articles portraying your health care system as blotted, gluttonous, and indifferent? Guilty of such socio-economic capital sins as: gross inefficiency, excessive cost overruns, and worshipping high technology at the expense of simply personalized patient care? While these fascinating journalistic renderings by a new breed of "over-night" experts in medical economics do reflect the near panic in governmental bureaucracies, corporate board rooms, and union offices over escalating costs of medical care, they have neglected to describe in any detail a dramatic alteration in health care financing which is about to significantly alter the traditional landscape of American medicine, possibly and unfortunately, for all time.

On October 1, the Federal Government, which presently pays 42% of the nation's hospital bill, began to phase in a new and radical method of payment for Medicare patients by providing prospective reimbursement for specific medical conditions classified under 467 diagnostic related groups (DRG). Eventually, this program of fixed financial allotments to hospitals will cover all Medicare recipients nationwide with payments based on the average hospital stay in nine geographic regions. Under this newly designed program, if you are a Medicare recipient and are admitted to a hospital for treatment of a disease or condition which falls within these DRG categories, your hospital will receive a set amount in payment, regardless of the cost of your hospital stay. Thus, if you should develop minor or major complications that justifiably extend your length of hospitalization and increase your medical costs, the government will no longer be obligated for these expenses. Who will absorb the unpaid costs in your medical bill? In all probability, the hospital will.

Within the next five years, the magnificent edifice of American medicine will be shaken to its very foundations as a result of this controlled method of health care financing. The true regulating factor in our medical system will be cost, not quality or access.

Additionally and unfortunately, the data being utilized for calculating these standard DRG hospital reimbursements are seriously flawed. Such information will be derived primarily from a cost analysis of hospital expenditures and lengths of stay, both notorious for their statistical unreliability and non-reproductibility. Indeed, even the DRGs themselves are considered inappropriate because they are not individually weighed by a severity index scale which indicates how truly ill the patient is. A study recently conducted at a large medical center demonstrated that the cost of a craniotomy varies from $1,808 to $155,005. In New Jersey, a state where a system of fixed reimbursement based on DRGs is already in effect and involves not only Medicare coverage but private insurers as well, the payment for hospitalization for such an operative procedure would be just $7,905!

Obviously, hospitals must develop strategies to prevent such financial losses, and, in the process, the danger of compromising patient care is all too obvious. Here are a few of these suggested tactical maneuvers:

1. To limit admissions to relatively well-off persons or not admit Medicare recipients;
2. To become more efficient by reducing the number of diagnostic

tests and limiting expensive treatments (thereby lowering the number of hospital personnel and equipment);

3. To employ techniques of "cost-shifting" to private patients and "diagnosis creep" by placing patients in higher financial rate classifications; and
4. To demand of its physicians early (and possibly inappropriate) patient diagnosis.

With the initiation of this revolutionary scheme of hospital payment by the Federal Government, which will surely "cap" rising medical expenditures in this country, it is only a matter of time before the private insurers implement their own programs based on the DRG concept of fixed hospital reimbursement. Soon, even your physicians will find themselves working with a predetermined fee schedule. Thus, within the next five years, the magnificent edifice of American medicine will be shaken to its very foundations as a result of this controlled method of health care financing. As a consequence, we must admit that, henceforward, the true regulating factor in our medical system will be cost, not quality or access. As a matter of fact, of the thousands of words written about the desperate need to suppress and control health care costs, very little has been mentioned about its effect on quality or access to health care in the future. In our health system, only medical doctors can determine what constitutes quality of care and, to date, they simply have not been involved in the decision making process leading to the design of this new financial blueprint for medical care delivery.

Only medical doctors can determine what constitutes quality of care and, to date, they simply have not been involved in the decision-making process.

Unfortunately, it is hard not to argue that, as this fixed reimbursement schema becomes all pervasive, the quality of medical care will not only become static, but very possibly will be lowered throughout this country. Predictably, the introduction of new methodologies of disease management and advanced instrumentation will be slowed under this radical payment system because they are expensive and would cause serious cost-benefit disequilibrium within such a financial system.

But, what of the poor and uninsured in this "new Wonder World of financial controlled medicine?" Tragically, because they will be without funds or grossly underinsured, they will be too "expensive" to be admitted to the private hospital and, consequently, they will have to seek medical care in specifically designated institutions and by a limited cadre of physicians — thus, we will have created a truly two-tiered level of health care in this country.

Welcome to American Medicine of the '80s — no longer personalized, sympathetic, innovative, or advancing, but now — cold, impersonal, stagnant, competitive, and computerized — yet, happily COST CONTROLLED!!! **OSMA.**

Robert J. White, MD, is Director of Neurosurgery at Cleveland Metropolitan General Hospital, and Professor of Surgery at Case Western Reserve University.

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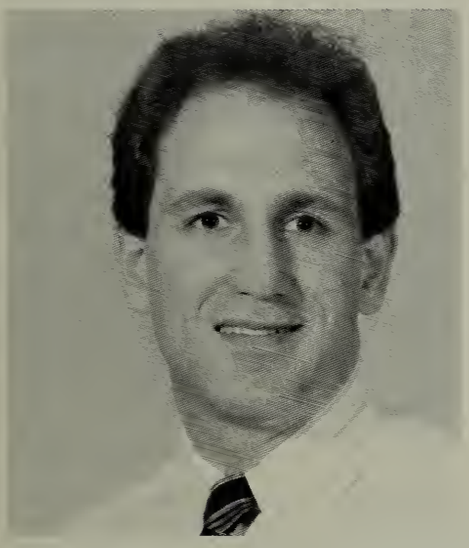
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Medical Students Elect New Officers

The Ohio State Medical Association's Medical Student Section has made its choices for 1984-1985. Meet the new officers . . .



J.R. Sarpa, President

J.R. Sarpa is expecting his MD degree in June, 1985, when he will graduate from the Medical College of Ohio at Toledo.

He currently holds a BS in biology and chemistry from Indiana University, and an MS in physiology from Ohio State University.

Sarpa has worked as both a graduate teaching assistant to the Department of Physiology at Ohio State University, and as a research chemist at Columbus' Battelle Memorial Institute.

Besides serving as a class representative to the OSMA-MSS since 1982, Sarpa also serves as a committee member on OSMA's Committee on Legislative and Judicial Affairs.

William F. Pomputius, III, Vice President

William F. Pomputius is a second-year student at Case Western Reserve University School of Medicine. He graduated summa cum laude with a degree in biochemistry from Yale in 1982.

The recipient of an Armed Forces Health Education Scholarship, Pomputius is expecting to serve as an officer in the Navy, where he hopes to be involved in aspects of infectious disease and public health.

Pomputius has been a representative to the OSMA-MSS for two years.





Judith B. Lavrich, Secretary

Judith B. Lavrich is expecting her MD degree in 1986 from the University of Cincinnati College of Medicine.

She presently holds a BS in chemistry from the University of Toledo, where she graduated magna cum laude.

Lavrich served as an AMA-MSS Delegate at the AMA I-83 Meeting, and has served as a representative to the OSMA-MSS for two years, including a term as treasurer of the medical student section. **OSMA**

NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by Susan Porter

Autopsy numbers continue to decline

Newer diagnostic techniques such as CT and angiography have led some physicians to believe that autopsies are no longer necessary. Yet a recent study conducted at a large Arizona community hospital indicates that a significant number of patients still are misdiagnosed and thus postmortem examinations remain a critical part of physician education and the quality of patient care, according to an article in *Medical World News.*

The study conducted at St. Joseph's Hospital in Tucson indicates that "19% of 100 consecutive autopsies performed over a two-year period revealed major missed clinical diagnoses," the article says. "A complete and accurate diagnosis probably wouldn't have changed clinical outcome for more than half these patients . . . but proper diagnoses might have extended survival for the remaining 42%."

These data suggest the possibility of premature death for 8% of all autopsied patients in the study."

The number of autopsies performed in the U.S. has decreased dramatically since the 1940s when about half of all patients who died in U.S. hospitals were given postmortem exams. Today, only about 15% of these patients are autopsied. In addition to more sophisticated means of diagnosing disease, fear of malpractice suits and the expense involved (about $1,000 per autopsy, for which no one is reimbursed) are reasons cited in the article for the decline.

Yet autopsies remain important, the study indicates, particularly as new diseases or those uncommon in prior years (such as systemic bacterial, viral and fungal infections) become more common and replace the better-known diseases which can be diagnosed through the new technology.



Will Diet Changes Affect Cancer Risk?

Changing dietary habits would probably reduce Americans' risk of cancer by only a small percentage, according to Michael W. Pariza, PhD, University of Wisconsin, writing in a recent issue of the *Journal of the American Medical Association.* He takes issue with recommendations made by the National Research Council in 1982 calling on Americans to reduce their fat intake to 30% of total calories and to minimize their consumption of cured, pickled and smoked foods. There is no conclusive evidence linking cancer to these or other specific elements in the American diet that would warrant such recommendations to the entire population, Pariza says.



OSMA Past President S. Baird Pfahl, Jr., MD, receives a plaque and a handshake from AMA Trustee John J. Coury, Jr., MD. The OSMA was honored with the membership plaque for exceeding its previous number of AMA members for the seventh consecutive year.

New Breast Cancer Test Called Investigational

Diaphanography (transillumination of the breast) is called an investigational technique by panelists of the AMA Diagnostic and Therapeutic Technology Assessment program, writing in a recent issue of the *Journal of the American Medical Association*. The procedure indicates normal glandular tissue, clear cysts, bloody cysts, or malignant changes by the various colors that appear on infrared-sensitive film. There is limited risk to the patient since ionizing radiation is not used. Still undergoing modification, diaphanography is already being compared favorably with mammography. Some report comparable results, but others say diaphanography is considerably less reliable. Large-scale controlled trials have yet to be reported.

Stroke Clubs Offer Hope for Patients

Stroke clubs can bring needed hope to patients, says Hugh Johnson, MD, writing in a recent issue of the *Journal of the American Medical Association*. His assertion is based on his own experience in recovering from a stroke. Told he would never walk again, he found that one visit to a stroke club offered renewed hope. None of the patients was in a wheelchair, and many were walking without canes. Regular visits bolstered the physician's confidence, and he now walks without a quad cane. Surprised to learn that some consider clubs "a nice social affair," Johnson urges all physicians to refer their stroke patients to local stroke organizations. A list is available through the American Heart Association.



The State Planning Committee for Health Education in Ohio (SPCHEO) is one of five organizations to receive a Community Health Promotion Award from the Ohio Department of Health.

OSMA has been active on SPCHEO during most of its 30-year existence. Shown receiving the award are: (l. to r.) Charles McMullen, MD, Loudonville, Chairman of the OSMA Committee on School Health, and OSMA's representative to SPCHEO; and Ellen Capwell, Ohio Department of Health, who serves as Chairperson for SPCHEO. Presenting the award is Thomas Halpin, MD, Columbus, who is Chief of Preventative Medicine for the Ohio Department of Health.

Marital therapy benefits male physicians

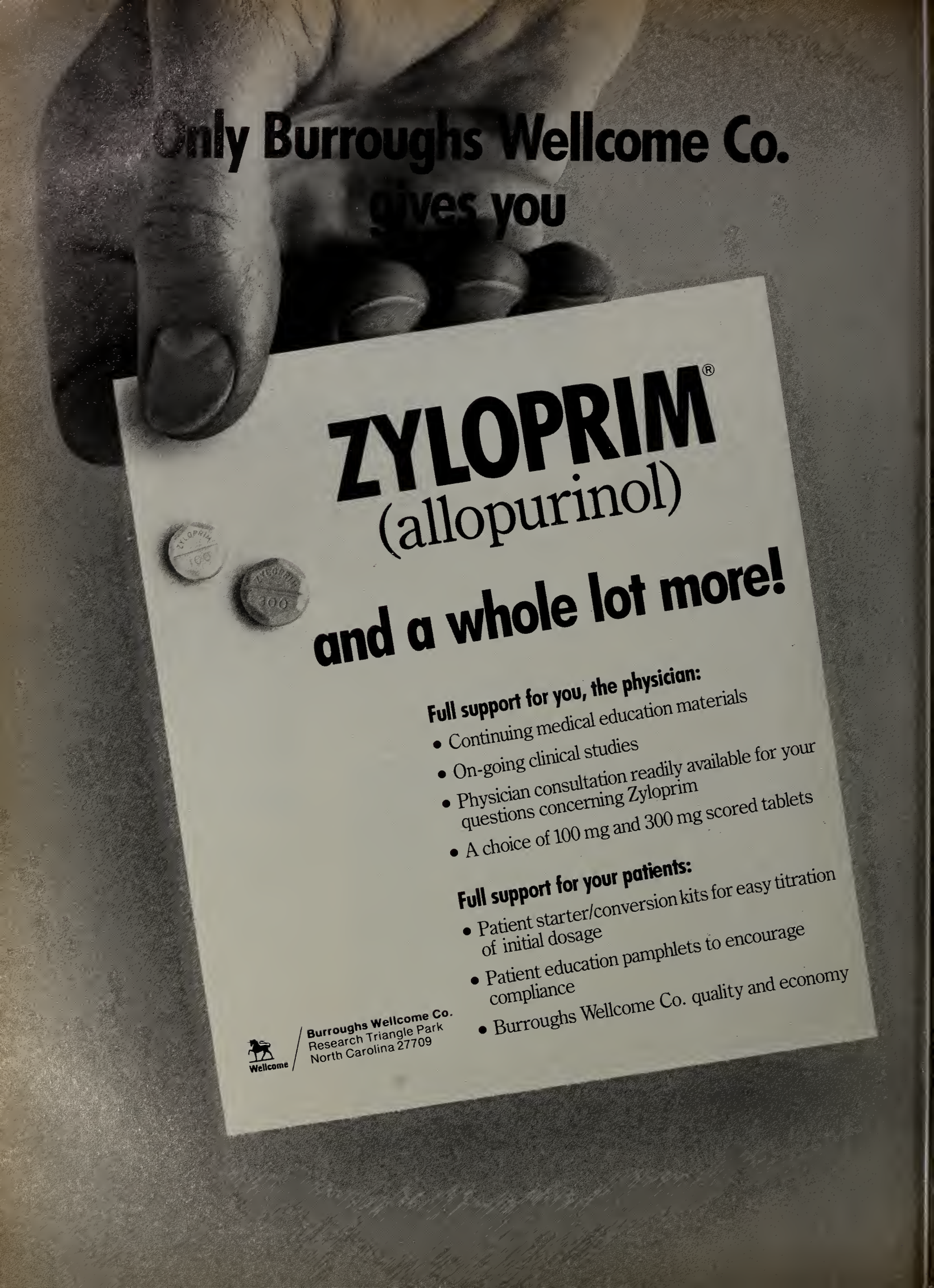
Physicians often have a difficult time as individuals relating their personal problems to psychiatrists and other physicians. However, marital therapy may become a way to solve both individual and marriage problems, according to a recent article in the *Journal of the American Medical Association*.

The authors, who studied 13 male physicians and their wives who had sought marital counseling for a variety of reasons, report that "Individual therapy for the troubled male physician has been reported to be difficult and often ineffective because of the physician's narcissism and heavy use of reaction formation and denial."

However, physician-husbands who sought counseling with their wives were able to overcome their discomfort and biases and to confront their problems, the report says. "We hypothesize that the presence of the spouse forces the physician to confront (problems) rather than deny them, offers an alternative view to the physician's narcissistic image, serves as a control to inhibit a troubled physician's self-destructive behavior and provides a persistent motivation for change."

The study indicates that while young physicians and their wives tend to seek marital therapy due to competition over career priorities and insufficient devotion of time to the marriage, middle-aged wives often resent sacrifices made earlier for their husband's careers, their dissatisfaction with the "doctor's wife" role, or difficulties with adolescent children. Among those couples 50 and over, problems most often center around the loneliness the wife experiences after the children leave home or the lack of a satisfying relationship after the physician-husband retires.

Regardless of the problem, it is important that both the physician-husband and his wife see a therapist together, the researchers note. They add that more study is needed on the individual and family problems of the growing number of female physicians.


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Why the OSMA Should not Bid to Become Ohio's Utilization and Quality Control Peer Review Organization (PRO)

By Susan Porter

To be or not to be . . . a PRO. That was the question pondered by members of the OSMA House of Delegates at a special session held this past April in Dayton, Ohio. The House voted down OSMA involvement with a PRO. Here's why.

INTRODUCTION

At its 1983 Annual Meeting, the OSMA House of Delegates voted to refer Resolution 12-82 (Report A) to the Council with the following instructions: *"Report A to be referred to Council with a report to all delegates and county presidents within 90 days of receipt of the government's regulations, and the Council's suggestions for implementation of PRO prior to entering into any contract."*

Following extensive study by Council and its Adhoc Committee and the release of federal guidelines concerning the PRO on February 27, 1984, the OSMA Council is now recommending that the OSMA *NOT* bid to become the PRO. This decision was reached due to the number of legal, economic and ethical concerns over the involvement of OSMA in this federally-coordinated peer review process. The following information explains why the Council arrived at its decision.

BACKGROUND

On September 3, 1982, President Ronald Reagan signed into law the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) which, among other provisions, included the Peer Review Improvement Act of 1982. The act repealed the Professional Standards Review Organization (PSRO) program, in effect since 1972, and replaced it with the Utilization and Quality Control Peer Review Organization (PRO) which allows physician-sponsored organizations, such as OSMA, to contract with Health Care Financing Administration (HCFA) to become the PRO in Ohio.

Peer review has long been recognized by members of the medical profession as an integral part of insuring quality in the practice of medicine. Beginning literally with the "pre" peer process of being granted admission to medical school, physicians both participate in and are the subject of numerous peer review procedures, including those required for state licensure, the granting of residencies, board certification in a medical specialty and the granting of practice privileges in a hospital setting. After privileges are granted, hospital medical staffs review and reevaluate every member's performance during the recertification process. In addition, hospital tissue and quality assurance committees review surgical procedures and patient care in the hospital.

With the advent of Medicare, Medicaid and other changes in the financing of health care, peer review took on a second dimension — that of controlling utilization and costs. Hospital Utilization Review (UR) committees were assigned not only the duty of insuring quality care, but also of monitoring the amount of services provided and of reviewing the necessity for the services provided.

Escalating Medicare and Medicaid costs prompted Congress in the early 1970s to establish an even more rigid review system, the PSRO program. PSROs were created with the "promise" that local physician-sponsored organizations would monitor the quality, appropriateness

and necessity of care delivered to Medicare, Medicaid and Maternal and Child Health patients.

As early as 1976, Congress began questioning the cost-effectiveness of the PSRO program and demanded evidence of the program's usefulness in controlling health care costs. A number of measures were undertaken to improve the program, but subsequent assessments of the program's effectiveness were less than positive and funding was withdrawn from several PSROs. This action, along with the continued rise in health care costs, primarily in the Medicare and Medicaid programs, prompted the repeal of PSRO provisions and the establishment of the alternative Utilization and Quality Control Peer Review Organization (PRO).

PROs — PURPOSES, FUNCTIONS, RESPONSIBILITY

According to recently released federal guidelines, PROs will differ from PSROs in a number of ways. Where PSROs were under annual grant or contract renewal, PROs will be awarded fixed-price contracts for two-year periods. PROs will be evaluated regularly against objectives negotiated at the time their contracts are awarded. PSRO objectives were generally not well defined nor enforceable. Unlike PSROs, PROs have the power and responsibility to enforce sanctions against physicians. Overall, PROs are to be held much more accountable to the government through contract conditions for their performance.

With the implementation of the Diagnosis Related Group (DRG) and the Prospective Payment System (PPS), PRO reviews will be tied much more closely with government cost controls and will be forced to place more direct emphasis on health care cost containment. Perhaps the most important difference between the PRO and the PSRO relates to the review/data interface: Under PSRO, data supported review; under PRO, data effectively "drives" review.

Under the new federal government guidelines, PROs must perform the following duties:

1. **"Consult" with the Secretary of HCFA as to what types of cases are to be reviewed.**
2. **Review "all or some" of the physicians and other health care practitioner activities and institutional and non-institutional providers of health care services for which payment is made under Title XVIII. In doing so, they must establish whether or not services rendered are: a) necessary, reasonable or allowable; b) meeting quality professional standards; and c) administered at the appropriate level.**
3. **Consult with those who are to be reviewed regarding the review to be undertaken of their professional activities.**
4. **Apply professionally-developed (but not necessarily locally derived) norms of care, diagnosis, and treatment, including type and extent of health care services and the most appropriate level of care.**
5. **Utilize other practitioners to facilitate and expedite review.**
6. **Promptly notify patients, physicians and providers if services are disapproved.**
7. **Collect and maintain records and data, as required by contract.**
8. **Coordinate activities with intermediaries and carriers, other PROs and other public and private review organizations.**
9. **Adhere to all regulations and directives promulgated by the secretary.**

In addition, the PRO plays a major role in insuring that physicians cannot manipulate the DRG system through such means as discharging and then readmitting patients; transferring patients to specialty hospitals exempt from PPS; admitting patients for surgeries that could be done on an outpatient basis; seeking outlier payments; compromising the quality of care by discharging patients prematurely or economizing on diagnostic workups.

To accomplish this, a major responsibility of the PRO will be to review:

- the validity of diagnostic information provided by hospitals;
- the completeness, adequacy and quality of care provided;
- the appropriateness of admissions and discharges; and
- the appropriateness of care for which outlier payments are made.

Therefore, PROs will be involved in the following specific functions:

Admission review — The overriding purpose of admission review is to reduce the number of unnecessary admissions and inappropriate transfers to PPS-exempt units and to identify premature discharges. Therefore, the PRO will be responsible for determining inappropriate admissions, transfers, readmissions, PPS-exempt reviews and admission pattern monitoring.

Permanent Cardiac Pacemaker Implementation Review — This function requires the PRO to review every permanent cardiac pacemaker implantation or reimplantation procedure and to obtain warranty information on every device. The PRO must deny payment for all "unnecessary procedures."

Quality Review — Under the quality review criteria, the federally-mandated emphasis will be on the appropriateness of services and patterns of care provided to stabilize the condition under treatment, as specified by the DRG. The sole objectives of quality review as defined by the federal government for PRO purposes are: a) to reduce unnecessary hospital admissions resulting from substandard care provided during prior admissions; b) to reduce avoidable deaths; c) to reduce unnecessary surgery or other invasive procedures; d) to reduce avoidable postoperative or other complications and e) to assure the provision of

medical services which, when not performed, have *significant potential* for causing *serious patient complications.*

"Significant potential" under item "e" is defined as 5% or more of cases that are subject to the problem. This must be demonstrated for any objectives in this category through published research or through data specific to the problem on which the objective is based. "Serious patient complications" refers to situations that require clinical intervention to avert threats to the patient's life or other adverse outcomes that extend a patient's stay or result in additional morbidity or physical limitation.

For purposes of PRO review, "quality impact" is to be measured as the reduction in the product of the number of patients affected by the problem times the "severity" of the problem. "Severity," which shall be determined by HCFA according to a special "Severity Index," is defined as the adverse effect of the problem on the patient. Severity "ratings" range from "10" where the problem is defined as "the actual loss of life," to a "3" where the problem is defined as "the underutilization of services with *significant potential* for *causing serious patient complications,*" again as defined above. The PRO contractor will receive credit for impact on the quality objectives only by using this measure. Review that does not result in "improved quality" as defined above will receive no credit. Therefore, "quality" review objectives concerning documentation or hospital management problems or problems with environmental, safety or other accreditation issues for which physicians are not directly and primarily responsible are not considered acceptable quality issues, according to the PRO guidelines.

DRG validation — PROs will be responsible for verifying information hospitals are required to submit under the new DRG system, including that related to diagnoses, procedures and codes. This will involve a review of patient medical records in order to determine errors or problems in coding or orders made by physicians.

Outlier Review PROs will be responsible for reviewing "outlier" cases or those cases where days of stay or cost of care significantly exceed DRG standards, in order to determine potential abuse of this category.

Additional responsibilities of the PRO are to:

- initiate and enforce sanctions;
- cooperate with HCFA, Office of the Inspector General and other Federal and State Agencies, by providing professional medical expertise and evaluation of medical records referred by such agencies as cases or patterns of suspected fraud or abuse, and
- establish external relations and physician groups, provider groups, fiscal intermediaries, other health care professional and private sector groups.

POLICY, ECONOMIC AND LEGAL CONCERNS

The OSMA Council maintains the position that "There is a continuing demand for accountability of physician decisions as they affect the economics of the health-care system in Ohio" and "A review of a physician's professional activity is best accomplished by the physician's colleagues in terms of objectivity, of necessary knowledge and of an appreciation of the nuances of decision-making in a clinical setting," as stated in Resolution 12-82. It has serious reservations, however, about the OSMA contracting to become the PRO in Ohio. In reviewing the functions, purposes and responsibilities of the PRO, it is apparent to Council that cost-containment is the primary objective of the PRO program and that quality of care analysis is to play a minor role in the PRO's review process. This federally-mandated objective is in conflict with the proper role of the OSMA as an advocate of the physician and the patient, a role that demands that quality care be the primary consideration.

In 1976, the OSMA House of Delegates adopted Amended Substitute Resolution 25-76 which states in part, *"When evaluation of the PSRO program by either this House of Delegates or the Council reveals that it adversely affects the quality of patient care or conflicts with the principles of medical ethics, the Council is instructed to use all professional and legal means to rectify the shortcomings of the PSRO program . . . RESOLVED, That the Ohio State Medical Association not actively engage in any new programs to enhance the government's PSRO program but lend its strength and expertise to the continued development of non-PSRO peer review . . ."* And in 1981, the OSMA House reaffirmed the Ohio Amendment to AMA policy on PSRO, *"that the current AMA policy shall be to continue professionally directed efforts to ensure that care provided to patients is of high quality and appropriate duration, and is rendered in an appropriate setting at a reasonable cost and to encourage the elimination of all government-directed peer review programs, including PSRO,"* again focusing on the principle of quality care to the patient. Resolution 12-82 and its subsequent Report A established the possibility of the OSMA implementing a statewide peer review system. **Faced with the PRO contract requirements, the Council concludes that to contract as the Ohio PRO could inhibit the OSMA's ability to be an effective advocate for issues of quality care.**

In addition, the Council has a number of economic and legal concerns over OSMA's involvement in the PRO program. While the total cost

continued on page 427

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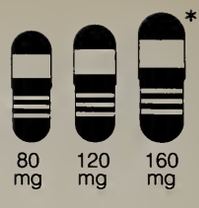
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DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end-diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by a delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the electrophysiologic action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the cranial vessels.

Beta receptor blockade can be useful in conditions in which because of pathologic or functional changes, sympathetic activity is detrimental. The beneficial effects also in situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-related tumorigenic effects at any of the dosage levels. Reproduction studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses no more than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; exacerbation of intermittent claudication; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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of implementing and operating the program has not yet been determined, it is obvious that the PRO program will be expensive to establish and operate, and that additional revenues would have to be raised, either through an additional dues increase, assessment of members or loans from financial institutions without the ability to recover interest costs from the government.

Under federal rules, the cost of preparation of a response to a request for proposal is not recoverable and advance payments to the PRO for startup costs are available only in cases of need or lack of credit. The total program budget will be limited to fiscal year 1982 costs of the PSRO program nationwide, and there will be a 10% holdback of payments to the PRO during the program's life. In addition, the PRO will be forced to provide documents to support all costs proposed, to maintain time/labor records, to meet federal contracting fiscal requirements and will be directly accountable to HCFA for performance of all aspects of the contract and all activities of any subcontractors.

Among major legal considerations are:

- Confidentiality, particularly as it pertains to the PRO's obligation to cooperate with HCFA and other federal and state agencies in cases where fraud or abuse is suspected.
- Potential liability for PRO's debts
- Federal employment and executive order obligations
- Unanswered antitrust questions

CONCLUSION

The OSMA Council therefore is recommending to the House of Delegates that OSMA not offer to contract with HCFA to perform the review services required by the PRO contract. It is the belief of Council that the technical and contract obligations placed on the PRO contractor are a significant conceptual change from the quality reviews originally intended by the authors of the PRO legislation. Furthermore, the current PRO contract requirements limit the PRO's ability to focus on issues of quality care.

RESOLUTION

Whereas, The 1983 OSMA House of Delegates considered Report A as required by Resolution 12-82, "Authority for Peer Review Functions," and referred it to OSMA Council with the following instructions:

Report A be referred to Council with a report to all Delegates and county presidents within 90 days of receipt of the governments' regulations and the Council's suggestions for implementation on PRO prior to entering into any contract"; and

Whereas, HCFA mailed the request for proposal (RFP) on February 29, 1984, and mandated bidders respond with a contract offer to HCFA no later than April 30, 1984; and

Whereas, The Council reviewed the requirements placed upon the prime Peer Review Organization contractor; and

Whereas, It is the belief of Council that the technical and contractual obligations placed on the PRO contractor are a significant change from the quality reviews originally introduced by US Senator Dave Durenberger (R-MINN), the author of the PRO legislation; and

Whereas, The PRO regulations and the RFP limit the PRO's ability to focus on issues of quality care; and

Whereas, The PRO regulations and its contractual requirements of the prime contractor mandate most of the proposed review to be made in terms of cost; and

Whereas, The Ohio State Medical Association believes its role to be advocate of physicians and patients in the health care system (not as an enforcer of government programs); now therefore be it

RESOLVED, That the House of Delegates of the Ohio State Medical Association approves the recommendation of Council that the OSMA not offer to contract with HCFA to perform the review services required by the PRO contract.

Susan Porter is assistant editor of the Ohio State Medical Journal.

Home Health Care Guide Available

With DRGs now in force, many physicians may be wondering how best to care for Medicare patients who no longer require hospitalization. A newly-published guide on home health agencies may help provide some answers.

The 1984 Ohio Home Health Care Resource Guide recently compiled by the Ohio Council of Home Health Agencies, lists more than 200 certified-for-Medicare home health agencies in this state. It is designed to answer "a long-standing need for accurate information and education about home health care in Ohio," according to Kathleen Dinsenbacher, RN, council president.

Along with a directory of all Ohio certified agencies, the guide includes information about the council, a listing of state and national resource agencies, an explanation of the home health care concept and a map showing location and types of the 200 home health agencies in Ohio.

The publication is designed as a reference guide for those in the medical profession and in the home health field, as well as the public. Its chief purpose is to assist those interested in providing comprehensive, coordinated quality home health care, Dinsenbacher says.

Anyone interested in a copy of the publication should contact the Ohio Council of Ohio Health Agencies at 101 E. Wilson Bridge Road, Worthington, Ohio 43085.



"Fast-food medicine," which courts consumers with its convenience and woos businesses with its costs, has spawned yet another type of alternative healthcare — outpatient or satellite clinics.

Are You Ready to Meet Your Competition?

Because, ready or not, here they come . . .

By Karen S. Edwards

So, you've leafed through this issue, maybe read some of the articles, and you're sitting there wondering, how bad is it?

"It," of course, refers to the competition you, as an Ohio physician, are facing, now that HMOs, IPAs, PPOs and other initialed providers are no longer figments of your imagination. But then, those alphabet-soup concoctions are givens. You already know about *them* — and probably have some idea already as to the impact they are having on your practice.

No, the "it" you fear the most is the 'it" that's unknown — the *other* kinds of marketing that have recently been initiated by your competitors, and of which you may be blissfully unaware. After all, how can you expect to compete with the competition when you don't even know what the competition is?

What this article hopes to provide you with is "the big picture" — a look at not only the *amount* of marketing being done by health-care providers across Ohio — but also at the *diversity*. You might just be surprised at the array of services currently being dangled before *your* patients . . .

The "Fast-Food Medicine" Competitors

For example, one competitor that has been around for a while now is the Free Standing Emergency Centers (FECs). Patients like them. They can drop by without an appointment, and walk out with a bill that can be anywhere from 25% to 40% cheaper than the hospital emergency room — and often cheaper than their private physician. And *that's* where the problems begin, because records to date seem to indicate that the centers are not really pulling patients away from hospital emergency rooms as much as they are from the private physician.

According to an article which appeared in the *Annals of Emergency Medicine* last year, it is suggested that the public may not perceive the FECs as a substitute for hospital emergency rooms, but rather as a substitute for the private physician's office.

And, in fact, in an article in *Changing Times*, the author points out that some FECs, such as MedFirst (which has 56 offices in 11 states, including Ohio) emphasize family practice and seek to establish an ongoing doctor-patient relationship. That's competition . . . and it's not going to go away.

According to the National Association of Freestanding Emergency Centers, there are 1,000 FECs currently in operation in this country, with 4,500 predicted by the year 1990.

So what are you going to do to compete effectively? Probably extend your office hours, for one thing. Gary Meller, MD, from Akron, president and medical director of a corporation which funds and builds FECs commented in a recent *Journal* article ("Freestanding Emergency Centers: An Identity Crisis Not Yet Resolved," *OSMA Journal*, October, 1983) that, in responding to the need to compete with FECs, more physicians offices will come to resemble them.

Now, if you are a surgeon or other specialist about to breathe a sigh of relief because FECs don't really affect you, don't let that breath out yet.

"Fast food medicine," which courts consumers with its convenience and woos businesses with its costs, has spawned yet another type of alternative health care — outpatient or satellite clinics.

These clinics — sometimes referred

to (by the media more often than consumers) as "Doc in a Box" — are being rapidly established across Ohio by both hospitals and individual physicians. Currently, the most popular place to find them is in or near a shopping mall.

But, again, patients like them. They offer convenience and services not provided elsewhere — and generally at lower costs.

The diversity of these clinics is what is most amazing, however. These freestanding facilities offer just about any kind of medical service you can think of.

The Ambulatory Surgery Centers are probably the oldest form of outpatient clinics, offering patients a low-cost, same-day service for minor operations. Nearly every hospital has its own, now — and a growing number of surgeons, and surgery groups are setting up their own clinics.

But the "clinic" story is no longer confined to just these types of facilities.

Here in Ohio, it is also possible to find:

- Full service clinics, which offer family practitioners and specialists under the same roof. In fact, some of these clinics have x-ray, lab service, and EKG stress-testing facilities as well, so the patient can get all of his/her medical needs taken care of in just one stop.
- Dental-Medical clinics, which allow a patient to go to the same place for both medical and dental needs.
- City Health clinics, which generally appeal to the lower-income patient, but consider this quote which appeared late last year in the *Cincinnati Enquirer*. The speaker was a 31-year old mother: "I bring all my kids here . . . I used to go to a private doctor, but they do much better here. They take the time to let you ask questions, and they don't have to hurry on to another patient."
- Orthoclinics, which are described as "progressive centers for orthopedic surgery and sports medicine."
- Medical Resource/Cardiac Rehabilitation Centers, which serve both the cardiac/back patient in need of rehabilitation and fitness enthusiasts. These centers may utilize stationary bicycles, running tracks, swimming pools and exercise rooms to lure patients to their facilities.

Surely other forms are just waiting in the wings . . . ready to descend like fast-food franchises on the medical community. It will be interesting to see what comes next . . .

Every profession has its trailblazers, and in a field as competitive as medicine is at the current moment, it is not surprising to see some brand-new services being offered.



The Housecall Revivalists

One of the newest marketing tools being used by professionals is the return of the housecall. Suddenly, doctors all over the country are starting to revive the old custom of visiting the sick patient at home — but the methods, sometimes even the motivation — can be widely different.

In some of the larger cities on both the east and west coasts (but also as close to home as Detroit), a "house call service" has been launched. All one needs to do (if one lives in these cities) is call the special service, and, for a fee, a physician will be at your bedside in an hour — any time of the day or night. The names of these services are eminently marketable — "Doctors on Call," "Doctors Housecalls, Inc.," "Mobile Medical Care," "Housecall, MD" — and, in view of the increasing elderly population in the U.S., it may be a service whose time has come. But can it survive as a separate entity, apart from a regular practice?

The question hasn't come up yet, in Ohio. There may be one or two doctors in the state who do *just* housecalls, but they are the exception more than the rule. Chances are too, however, that more and more physicians are going to add housecalls to their list of services — that "extra mile" they take to make their practices more appealing to patients.

Some have already started, and are quick to point out the advantages of home visits, such as strengthening the bond of trust between the doctor and the patient. Others claim home visits can be informative, allowing the

physician to make a better diagnosis, once he/she has seen the environment in which his/her patient lives. But critics claim housecalls can also rob patients — especially elderly patients — of that psychological boost they need to get up and out of the house, and to the doctor's office. House calls, too, limit the number of patients that can be seen in a day (in the hour or more it takes to make a house call, a doctor could see from four to six patients in the office — so it is not a cost-effective practice by any means). And without all the necessary equipment a doctor usually has on hand, a housecall can make a physician feel less than comfortable.

Still, the housecall has become a viable option in today's marketing arena. And chances are, we'll be seeing much more of them.

The Do-It-Yourselfers

As if hospitals, other physicians, and paraprofessionals weren't enough for today's doctor to have to contend with, modern science has elected to present the "patient do-it-yourself kit."

Patients can now test themselves for diabetes, high blood pressure and pregnancy — and soon, thanks to a new kit recently approved by the FDA, the patient can actually do the doctor one better and determine the sex of her child right in the comfort of her own home.

Other patients, who want to get more technical, can take home an eye test and determine not only their visual acuity, but check for symptoms of macular degeneration.

Where does all this leave the doctor? Well, fortunately, right in the middle of things. After all, once the symptoms have been discovered, there is really only one place the patient can turn for treatment — the physician. Unless, of course, someone has recently come up with a treat-yourself kit . . .

The Innovators

Every profession has its trailblazers, and in a field as competitive as medicine is at the current moment, it is not surprising that we see some brand-new services being offered.

Ohio's latest is called a "transmed van," and, according to an article in the *Solon Times*, Solon, Ohio, the 32-foot van transports health services to industrial sites.

Businesses often require physicals of both their executives and new employees, but by the time the employee schedules a doctor's appointment, takes time off work, then waits in a physician's office, the businesses sometimes have second thoughts as to whether or not the annual or new employee physical is worth it.

Raghaven Chari, MD, Solon, has come up with an idea to make the whole process much easier. By equipping a van like a physician's office, and staffing it, Dr. Chari is able to provide physical exams for business without making the employee fight traffic, parking, or long waits at the doctor's office.

"An executive or worker doesn't have to leave his job until his appointment," the article quoted Dr. Chari as saying. The transmed van pulls into a parking space at the place of business and waits for the patient to walk directly from the job to the van. When he/she arrives, Dr. Chari can administer hearing, breathing and eye tests (results in moments, thanks to a microcomputer); take chest and low back x-rays (film in 90 seconds); give exams, use a treadmill for stress testing, order electrocardiograms, or use the centrifuge for blood tests.

A design for a two-van system, offering more space and luxury is underway and Dr. Chari is already talking about going national with his concept, including franchises. So stand back. A new type of health care delivery is on the go . . .

The Hospital Fallout

The trouble with competition is that it's everywhere, and hospitals have most certainly been one of the hardest hit health care providers, as far as the marketing game is concerned. With hospital admissions dropping rapidly (admissions dropped about 88,000 in the first 11 months of 1983, reports the American Hospital Association), hospitals are scrambling for patients — as well as their own survival — and in the wake of their ongoing, often zealous marketing strategies, physicians are often caught in the fallout.

As hospitals offer more and more services, physicians are finding themselves stretching their own practices in order to keep up. Which makes hospitals offer *more* services, and so on, in a circle that's too bizarre to call vicious. Actually, neither physician nor hospital are in deadlock competition with each other yet. But it may be just a matter of time.

As hospitals venture further into the for-profit arena, they are bound to create competition with and among private practitioners. For example, some hospitals are now offering physician referral services to the community, referring those in need of a doctor (whatever specialty) to one of the hospital's own medical staff members. If you aren't on that hospital's staff, consider the competition one up on you.

The examples of competition taking place in Ohio can go on and on. The picture keeps getting bigger every year, and now, a new business has been created by enterprising individuals who want to help you, the physician, market your practice — bring you into the picture, so to speak. Whether or not you choose to enter that picture is based on your will to survive. Critics can claim that competition is debasing the profession, eroding ethical consideration, and causing the public to trust hospitals and physicians less and less. But until *everyone* drops their guard, no one person (read "physician") can afford to do so. **OSMA**

Karen S. Edwards is Executive Editor of The Ohio State Medical Journal.

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CONTRACT MEDICINE: The Strongest Competitor on Health Care's Horizon

By Susan Porter

As recently as a decade ago, the relationship between doctor and patient was a relatively simple and informal one. The patient selected the physician of his or her choice based on a personalized set of criteria: past experience, the recommendation of a neighbor or friend, convenience to home or work, referral by another physician, reputation in the community, etc. And the "contract" between the physician and the patient was a verbal and informal one: an exchange of services rendered, as requested by the patient, for a payment of fees, as determined by the physician.

But for a wide variety of reasons —

mostly related to cost-containment — a lot of this is changing. Health care costs now, to a large degree, are paid not by patients but by third-party payers who, in turn, are paid premiums by business and industry — and all are constantly looking for ways to reduce their share of the bill. Out of this effort have arisen alternative means of delivering health care — Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Individual Practice Associations (IPAs) and other arrangements — all of which allow the payer to, in some form, negotiate fees and other arrangements with the physician.

As a result, physicians today are being approached in large numbers to sign contracts to become a part of these organizations, in exchange for promises like increased patient loads and prompt payment of services. Perhaps the greatest incentive to signing on the bottom line is the fear that the physician who does not join will somehow be left out in the cold — will be passed up by the constant stream of patients who will be beating a path to the HMO, PPO or IPA-member physician down the street.

According to Robert E. Holcomb, director of field service and marketing for the Ohio State Medical Association, there is hardly a physician in the state who has not at least been approached to sign a contract and nearly half have chosen to do so. Most, however, have managed to retain their private practices, in addition to signing special agreements as members of IPAs or PPOs.

To date, there are 17 HMOs and HMO/IPAs in the state he relates, and nearly every part of the state has access to at least one of these. While the HMO has been in existence here for a number of years, the PPO is relatively new to Ohio — the first one was started in Cleveland in February of 1983, and since that time 10 more have sprung up around the state, with more on the drawing boards.

The activity in Ohio has been nothing, however, compared to California, where the state medical association has been forced to set up a special "Department of Contract Evaluation and Negotiation Services" to keep up with the growing list of agencies soliciting contracts with physicians. According to Richard Robinson, manager of that department for the California Medical Association (CMA), a new law that created Medicaid as a contracting agency for health care recipients passed in that state a year and half ago has seen the number of contracting organizations rise from five to over 160, "and the list is growing every day."

There is hardly a physician in the state who has not at least been approached to sign a contract and nearly half have chosen to do so.

One reason physicians have difficulty making decisions regarding these contracts is there are no set rules or definitions of what a PPO is or does. Basically, the CMA has defined PPO for its members as "a group of health care providers (professional and/or institutional) which contract on a fee-for-service basis with employers, insurance carriers or third party administrators to provide comprehensive medical services to enrollees." But the entity comes under many names and in many shapes and sizes.

"If you lined up 20 doctors, 20 lawyers, 20 health care professionals and asked them all what a PPO is, you'd get a different answer from everyone," Robinson is quoted as saying in a recent issue of *LACMA Physician*, the publication of the Los Angeles County Medical Association. "The only people who are experts on PPOs are the people who are selling them, and I think that physicians should be very leery of anybody who is selling anything to them. That's about the most important thing people can remember — there is no rush to sign anything and to be particularly leery of anybody selling contracts."

His department was formed to track and monitor all of these contracting agencies; to disseminate information about contracting, in general, to member physicians; and to perform written objective analysis on contracts being offered individual physicians.

"We don't advise them about what to do or not to do — we don't say whether the contract is a good or a bad one. We simple try to explain to them the provisions of the contract." Already, says Robinson, some 60 to 70 contracts have been analyzed by his department and another 50 are awaiting review.

While the Ohio State Medical Association's Department of Legal Affairs does not review individual contracts, that department is following closely those organizations which currently are seeking to contract with physicians.

Robinson says physicians can evaluate their own contracts by performing a simple test. "Take a piece of paper, draw a line down the middle, and on one side list the legal obligations you are assuming," he suggests. "On the other side list the obligations that the business entity is assuming. Then compare the two for yourself."

More specifically, his department has published a booklet called "Physician's Contracting Handbook" which gives general guidelines on contract law, antitrust considerations, conduct physicians should avoid, the

types of contracts being offered and questions to ask about a contract.

"Physicians must never forget that a contract is a legally enforceable agreement. Therefore, the utmost care and thought must be given to understanding the legal obligations created by a contract," the booklet says.

The following list of questions is being reprinted from the booklet with the permission of the CMA Department of Contract Evaluation and Negotiation Services. While the list shouldn't be considered a substitute for an attorney's advice, it will at least give physicians an idea of the kinds of questions that need to be answered before signing on the bottom line.

1. Are all the parties to the contract clearly identified by name? Can the physician identify each and every party to the contract?

2. Does anybody or any entity other than the physician control determinations as to quality of care?

3. Under what circumstances can the physician terminate the contract? What action, notice and/or conduct on the part of the physician is specifically required to terminate the contract? What period of time is involved?

4. Does the contract permit unilateral changes in terms and conditions of the agreement without prior notice to the physician and/or without the prior assent of the physician?

5. If payment to the physician is subject to a percentage withhold, can the withhold percentage be changed unilaterally without prior notice to the physician and/or without the prior assent of the physician?

6. Does the contract provision on medical records comport with state law?

7. If the contract states that the physician will be bound by Articles of Incorporation, bylaws and/or other documents, has the physician reviewed such documents? Is there a contractual provision for the physician to be advised or modification of such documents? Is the physician bound by such modifications?

8. What financial obligations does the contract create for the physician? Is the physician liable for any charges for services he orders?

9. Does the contract limit referrals to "contract" for specialists? Is there a mechanism in the contract for the physician to be made aware of "contract specialist"? Does the physician assume any financial liability if he/she refers a patient to a non-contract specialist?

"Take a piece of paper, and draw a line down the middle. On one side list the legal obligations you are assuming; on the other, list the obligations that the business is assuming. Then, compare for yourself."

10. Does the contract limit referral of patients to "contract" hospitals? Are "contract" hospitals identified in the contract?

11. Does the contract limit referral to "contract" laboratory and/or x-ray facilities? Are contract laboratory and/or x-ray facilities identified in the contract?

12. What co-payments, if any, are patients responsible for under the contract? Can the amount of co-payment be unilaterally changed and/or eliminated under the contract?

13. Does the contract limit the physician's independent and professional judgment regarding the involvement of an assistant surgeon, anesthetist, etc.?

14. Is there a contractual time limit for the submission of claims? Is there a contractual time limit for the payment of claims? Is there a contractual penalty, such as some defined rate of interest, for delay in receipt of payment?

15. Does the contract mandate that a claim of professional liability against a physician be submitted to final and binding arbitration? What procedure is utilized in the arbitration process? What time limits are involved in the arbitration process?

16. Does the contract require the physician to maintain minimum medical malpractice insurance?

17. Will the physician have some readily available method of identifying patients under a contractual relationship? Does the contract require that the physician call and verify patient identification prior to each consultation?

18. Are non-covered charges clearly defined in the contract? Is the patient liable for payment of non-covered charges?

19. Does the contract allow the physician's name to be used on brochures, other advertising, radio and/or TV?

20. Does the contract make reference to a peer review and/or utilization review program? (What are the physician's responsibilities to provide records or perform peer review for the organization?) Has the physician obtained a copy of the plan? Are the procedures of the plan subject to unilateral change without prior notice to the physician and/or without the prior assent of the physician?

21. Does the contract require written and/or other prior

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Physician Advertising — What is Legal? What is Ethical? What is Acceptable?

By Susan Porter

Since the early days of medicine, when herbal potions and other concoctions were sold off the backs of wagons, and testimonials from prominent citizens were used to promote the latest "cure-alls," organized medicine has been uncomfortable with physician advertising.

In fact, one of the major reasons for the formation of the American Medical Association (AMA) in 1847 was to prohibit just such activities by setting high professional standards or codes of ethics for the practice of medicine.

The association and its affiliate state and county medical societies felt so strongly about the issue, that until recent times, many still frowned upon measures as simple as printing up business cards or listing in the yellow pages. But recent decisions in the courts and occurrences in the marketplace have resulted in a number of changes.

Today, it is not at all unusual in many parts of the country to see billboards, newspaper ads and TV spots promoting the services of a certain hospital or group of physicians. Perhaps the least hesitant to advertise are the new health care organizations — the HMOs, urgent care centers and other private and corporate-owned facilities anxious to get the word of their existence out to the local public.

As a result, more and more individual physicians in private practice are finding the need to market their services as well, through various forms of media and advertising. Whether it be the development of a logo for the office stationary or a 30-second spot on a local radio station, there are certain considerations physicians should keep in mind when planning promotional activities.

State Codes

According to the Statutes of Ohio (Sec. 4731.22), the state medical board has the power to revoke or refuse a license to any physician "soliciting patients or publishing a false, fraudulent, deceptive or misleading statement." The latter is further defined in the code as "a statement that includes a misrepresentation of fact, is likely to mislead or deceive because of a failure to disclose material facts, is intended or is likely to create false or unjustified expectations of favorable results, or includes representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived."

Thus, false or disceptive advertising in the medical profession is illegal, just as it is in other business and professional activities. However, a physician, hospital or group of physicians is permitted to disseminate information about his or her services through the local media. In fact, the federal government has been quite explicit in stating that it is illegal for any organization or state to prohibit physicians and other professionals from advertising.

The AMA's Views

Following rulings in the Supreme Court and actions by the Federal Trade Commission to ensure fair trade within the professions, the American Medical Association issued its views on advertising and publicity. According to the most recent (1984) *Current Opinions of the Judicial Council of the American Medical Association:* "There are no restrictions on advertising by physicians, except those that can be specifically justified to protect the public from deceptive practices." The policy goes on to state that, "A physician may publicize himself as a physician through any commercial publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television or other advertising) provided the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive."

It goes on to state that all communications and advertising should take place "in a direct, dignified and readily comprehensive manner." Furthermore, "Aggressive, high pressure advertising and publicity may create unjustified medical expectations. Any advertisement or publicity, regardless of format or content should be true and not misleading."

The AMA goes on to suggest that the advertisement include: "(a) the

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ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg.



"In Florida, it's not at all unusual to find billboards advertising doctors' services up and down every highway, but San Franciscans are amazed at the advertising that's even going on in Ohio."

educational background of the physician; (b) the basis on which fees are determined (including charges for specific services); (c) available credit or other methods of payment; and (d) other information about the physician which a reasonable person might regard as relevant in determining whether to seek the physician's services."

What it should not include, however, are "testimonials of patients as to the physician's skill or the quality of his professional services," along with statements "that a physician has cured or successfully treated a large number of cases involving a particular serious ailment," which "may imply a certainty of result and create unjustified and misleading expectations in prospective patients."

The AMA policy also warns that "Statements relating to the quality of medical services are extremely difficult, if not impossible to verify or measure by objective standards." However, it continues, "Claims regarding experience, competence and the quality of the physician's services may be made if they can be factually supported and if they do not imply that he has an exclusive and unique skill or remedy."

Furthermore, the policy continues, ". . . a physician who is considering the placement of an advertisement or publicity release, whether in print, radio or television, should determine in advance that his communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser and those which a reasonably prudent advertiser should have discovered."

Local Acceptability

While the federal law has come out strongly in favor of physician advertising, and organized medicine has agreed that newspaper, magazine, telephone directory, radio and television and other forms of advertising fall within its guidelines, it is important that physicians look at their own local markets before determining what kinds of advertising will be acceptable in their local communities.

Acceptability can vary a lot from state to state, says Janeen Adrion, a marketing director for the American Medical Association who recently conducted a seminar titled "Marketing Strategies for Private Practice," for the OSMA. For instance in Florida, she says, "It's not at all unusual to find billboards advertising doctors' services up and down every highway." In Southern California this kind of advertising is equally common; however, "In Northern California it is not. San Franciscans are amazed at what's going on even in Ohio."

Because competition is the "fiercest" in the sunbelt states, advertising is much more common there than in parts of the country with fewer physicians, says Dick Endres, another marketing director at AMA. Also, "There is a high correlation between the metropolitan nature of the community and the amount of competition and therefore the advertising that goes on there," he says.

In terms of patients, studies show that most are not offended by physicians who share information about their services and fees through the media. However, many doctors continue to feel this is inappropriate or unethical, although their acceptance of advertising tends to vary with age and with specialty, according to Endres, with the younger doctors more favorable towards promotional activities and the specialists "steering clear of them."

Acceptance of advertising in a geographical area is also closely related to other factors, such as the oversupply (or undersupply) of doctors in that area, the number of active business groups in the area, the general socio-economic status of the area, the aggressiveness of local marketing groups and the number of for-profit hospital chains in the area, says Endres.

Still, a great many doctors will verbally disclaim all advertising, even though, to some degree, most of them are doing it, Endres says. "If you substitute the word 'communicating' for the word 'advertising' you would find many more doctors in favor of it," he says. Endres includes business cards, yellow pages listings, announcements of practice relocations and even the sign on the office building as forms of advertising that most doctors now accept readily.

Perhaps the most acceptable form of advertising among doctors, says Adrion, is the "patient information handbook" — a personalized booklet listing the physician's hours, location, services and fees, which is handed out in the office during patient visits. Many physicians also feel more comfortable promoting their practices through more discrete measures: sponsorship of health fairs, health screenings and health seminars; participation in other community

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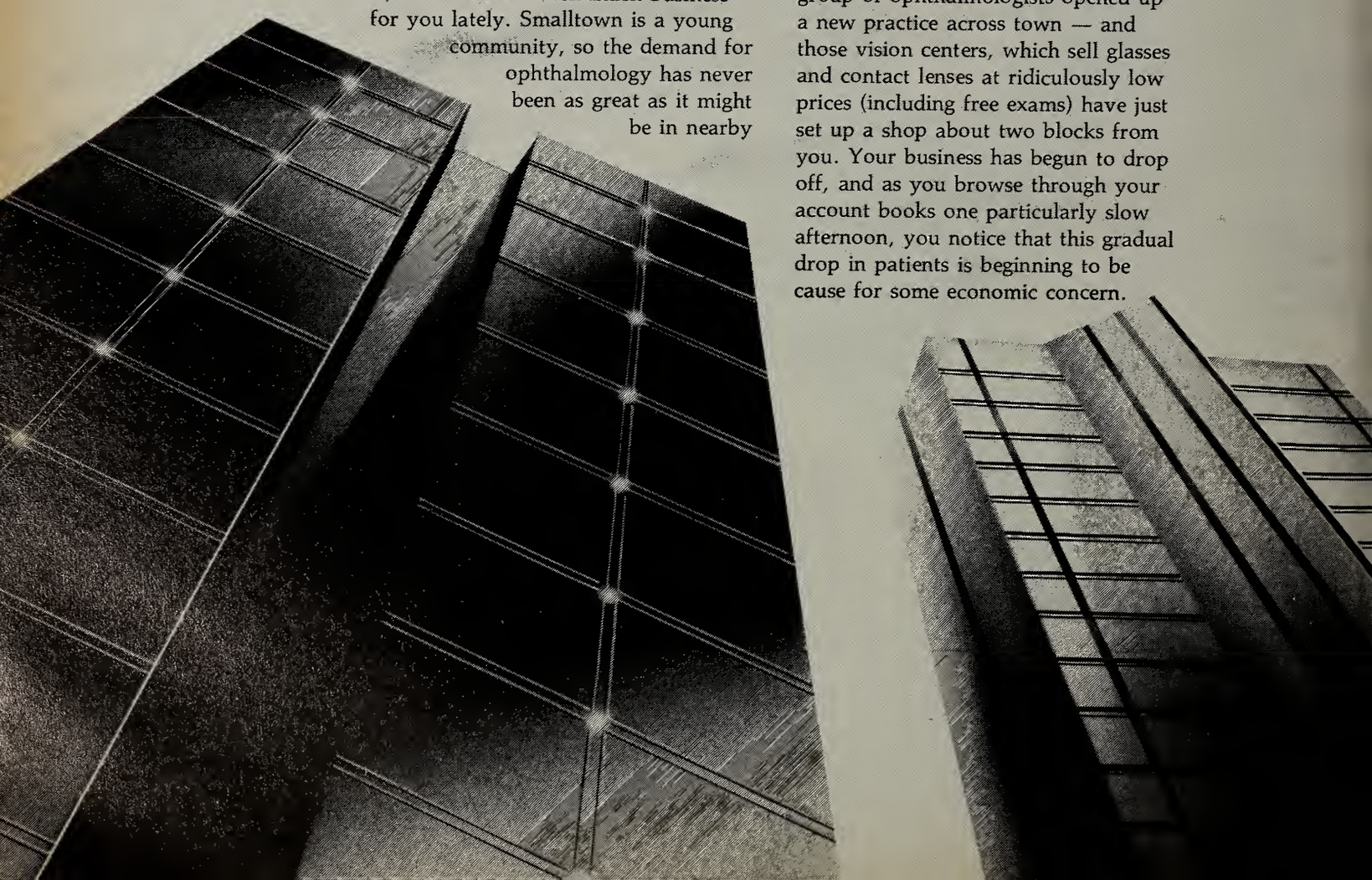
This Town Isn't Big Enough

If competition gets too tough, there is always another option . . . relocating your practice. It may be easier than you think.

By Karen S. Edwards

Let's say that you are an ophthalmologist who has been practicing for the past two years in Smalltown, Ohio. The only problem is, there has not been much business for you lately. Smalltown is a young community, so the demand for ophthalmology has never been as great as it might be in nearby Metropolis. Still, you like Smalltown and, until lately, there have been enough patients to keep you busy.

Then, about six months ago, a group of ophthalmologists opened up a new practice across town — and those vision centers, which sell glasses and contact lenses at ridiculously low prices (including free exams) have just set up a shop about two blocks from you. Your business has begun to drop off, and as you browse through your account books one particularly slow afternoon, you notice that this gradual drop in patients is beginning to be cause for some economic concern.



What do you do? Well, there are a couple of options open to you. One, you can pitch yourself into marketing your practice, hoping that by making it more competitive with the other businesses in town you can increase your *own* business. Or, you can look around for somewhere else to practice . . .

This issue of the *Journal*, as well as an article that ran this past March ("A Better Mousetrap," *OSMA Journal*, March, 1984) have already examined the issues of physician marketing and advertising. So this article will take a look at that *other* option . . . relocating your practice.

. . . As you continue to flip through the pages of your account books, you begin to think about nearby Metropolis. You've been there a couple of times, but you don't really know much about the place. How many ophthalmologists already practice in the "big city?" What is the age range of Metropolis' community, and what are its hospitals like? Can it economically support another ophthalmology practice?

Then, as the pages continue to fly past you now — unseen — you begin to consider some of the other issues raised by such a move. What are its schools like? After all, you have two children to educate. What kind of homes are available? And, more important, what will your spouse think about moving to Metropolis?

Only you — and your spouse — can answer that last question, but all of the other questions can be answered for you by a brand-new physician placement service, recently initiated by the Physicians Administrative Corporation of Ohio (PACO), the practice management arm of the Ohio State Medical Association (OSMA).

The service, which was launched in February, takes OSMA's former placement service and brings it into the high-tech world of the eighties.

"Before, when a physician wished to relocate, or a hospital wanted to hire a specialist for its staff, the details would be written down, and an ad would be placed in the *Journal's* classified section, with replies sent to a certain box number," says David Pennington, PACO's President. "When the replies come in, they would be sent, unopened, to the physician or hospital staff member who placed the ad. The OSMA had no other involvement."

But times change. OSMA began to receive more and more requests for listings.

"Increased competition has to take responsibility for some of this push to relocate. If you are not making it economically in your practice because of competition, it gives you a strong impetus to relocate."

"Requests for placements were not just coming from young physicians like you might think," says Robert Holcomb, OSMA's Director of Field Service and Marketing whose department handled the calls while it was just a listing service, and who is now working with PACO on the new placement project. "We began to get physicians who were in their middle years, with established practices — a very untraditional group."

"Increased competition has to take responsibility for some of this push to relocate," says Pennington. "If you are not making it economically in your practice, because of competition, it gives you a strong impetus to relocate."

But declining practices aren't the only reason physicians want to move, adds Holcomb.

"Today's middle aged physicians are more mobile than their predecessors. They're willing to move about more — for a variety of reasons."

Where they move, however, is beginning to carry more and more significance in today's competitive environment.

"You're taking a risk if you just move into an area without first finding out what you can about the community," says Pennington.

And that's where PACO's service comes into play.

"When a client retains our services, we don't simply match names and call it a marriage," says Pennington. "There is compatability to be considered on both sides."

The client is first interviewed, with spouse, if possible, to determine where they want to relocate. The client's social needs are taken into consideration; his/her taste in homes; and what he/she needs in the way of schools and social activities. Then, the placement service goes to work.

"We have the technology and the contacts within the medical profession to thoroughly research any area we need to. Once we are done, we can present our client with not only a profile of the community, but an in-depth market analysis, tailored to his or her need as well," Pennington says.

In determining a community's profile, PACO conducts interviews with local business leaders, the Chamber of Commerce, the hospital board of trustees, and members of the school system. Where appropriate, physicians in the community will also be interviewed to assess compatibility of established specialties, existing

"It is getting more and more important — with the advent of increased competition for patients — for physicians to consider the viability of a practice site. He or she should consider not only the potential maximum patient visits over a given period, but the portion of this market the physician can expect to capture."

referral patterns, volume of patients, collections, etc.

PACO will also make a tour of the hospital to learn about its services and facilities, the equipment available for physician use and the medical staff complement. Possible practice sites, both existing and potential, will be visited — and potential opportunities for the spouse are also considered.

"With increasing frequency, now, the physician's spouse will often have his or her own career to pick up and continue," says Holcomb.

All of this information, is then written up and given to the client. "We take a real hands-on approach with our clients, Pennington says, explaining that PACO will schedule visits to potential practice sites with the client so that he/she can see, first-hand, what the community has to offer.

"We take them in and introduce them to contacts we've made there on prior visits, so that they begin to meet people right away. If they decide to move in, they already have acquaintances."

In addition, a marketing analysis, in terms of practice site assessment is also made.

"It is getting more and more important — with the advent of increased competition for patients — for physicians to consider the viability of a practice site. For example, he or she should consider not only the potential maximum patient visits over a given period of years, but the portion of this market the physician can expect to capture," says Pennington.

PACO's system can provide this information not only by county — but by zip code — "so we can get right to the street where the client wants to practice," Pennington says.

In addition, PACO will:

- Analyze the expected case load and case mix of a practice in a given geographic market.
- Forecast future patient utilization rates.
- Evaluate the specialty services available in a particular geographic area.
- Forecast how many physicians of a given specialty may be needed in the area in the future.
- Do an indepth analysis of all available hospital facilities, including services sponsored by the hospital, required medical-staff credentials, and specialists represented on the medical staffs.
- Tell the client about the resources available in a community to help him/her establish his/her practice.

And since income is the fundamental financial determinant to *all* physician practices, PACO determines what the income adequacy is; predicts what income can be made in a given location; and considers the area's competition.

"Competition can drastically affect the market share a practice can expect to capture, so we study like services offered by like physicians in the client's potential service area; consider whether nearby hospitals are attempting to attract ambulatory care patients for their clinics; and determine whether health care reimbursement contracts with HMOs or PPOs are restricting patients to specified providers," Pennington adds.

PACO will help out in any negotiations that may need to be made prior to relocating, and it also offers a follow-up six-month practice management service to the client, which reviews physician reimbursement during that six-month period, the relationship developed with third-party payers, and other client needs.

"Because of our relationship with organized medicine, we take the role of physician advocate," Pennington says. "We do what we can for the physician."

Placement, of course, is a two-way street, and a hospital is as likely to be a PACO client as a physician. Still, PACO continues its role as physician advocate.

"When a hospital contacts us, seeking a physician, we contact our list of established physician contacts, residency programs, hospitals, medical centers, military facilities and established practices with physicians in

"Requests for placements were not just coming from young physicians, like you might think. We began to get physicians who were in the middle years, with established practices — a very untraditional group."

the needed specialty(ies) to tell them about the opportunity," says Holcomb.

PACO actually seeks a large volume of response from telephone, mail and personal visit activities. All Ohio residencies, with physicians or the needed specialty for example, will be contacted, as well as those physicians in residencies in surrounding states, who have expressed an interest in practicing in Ohio.

"We do preliminary screening by telephone," says Pennington, "and the evaluation begins when a physician in a specified specialty verbally expresses interest in the opportunity, offers the desired medical services, agrees to the location, and the spouse is equally willing to relocate."

Potential candidates are given additional information about the opportunity to qualify their interests, then, if they are still interested in the position, curriculum vitaes are requested, as well as references.

"We do review the cvs, and at least four out of the six references we require are checked out," says Holcomb.

The cvs are submitted to the hospital client, and a consensus is reached between the hospital and a PACO representative to determine which candiates are to be pursued for the position. Since PACO requires that personal candidate interviews be conducted if it is geographically feasible, the prospects for the position are narrowed down, and likely candidates are invited to the community for interviews — coordinated by PACO representatives.

"The system works out very well, and, of course, we're keeping the physician's interest in mind the whole time," says Pennington.

The most astonishing part of this entire service is its cost. For a fraction of what is often charged by most "headhunters" in the business, PACO will conduct an 18-month search per contractual arrangement, working on a retainer basis, which is payable within the first three to six months. Both the client and the company have the right to terminate the search for legitimate reasons, given a 15-day notification.

PACO also offers educational seminars throughout the year — including how to market your service — so if you aren't ready for the relocation step yet, you can pursue that "other option."

Still, if you are practicing in Smalltown, Ohio and Metropolis is looking more and more appealing — to both you and your spouse — that big move needn't be done in one giant step — or even alone.

Through the foresight of OSMA and its practice management company, PACO, there is now someone out there who can help you through the agonies — and eventual ecstasies — of relocating your practice. **OSMA**

Karen S. Edwards is the Executive Editor of the **Ohio State Medical Journal.**

Anyone wishing further information about PACO's new placement service should contact: The Physicians Administrative Corporation of Ohio, 450 W. Wilson Bridge Rd., Worthington, Ohio 885-6666.

Physician Advertising. What is Legal, Ethical, Acceptable?

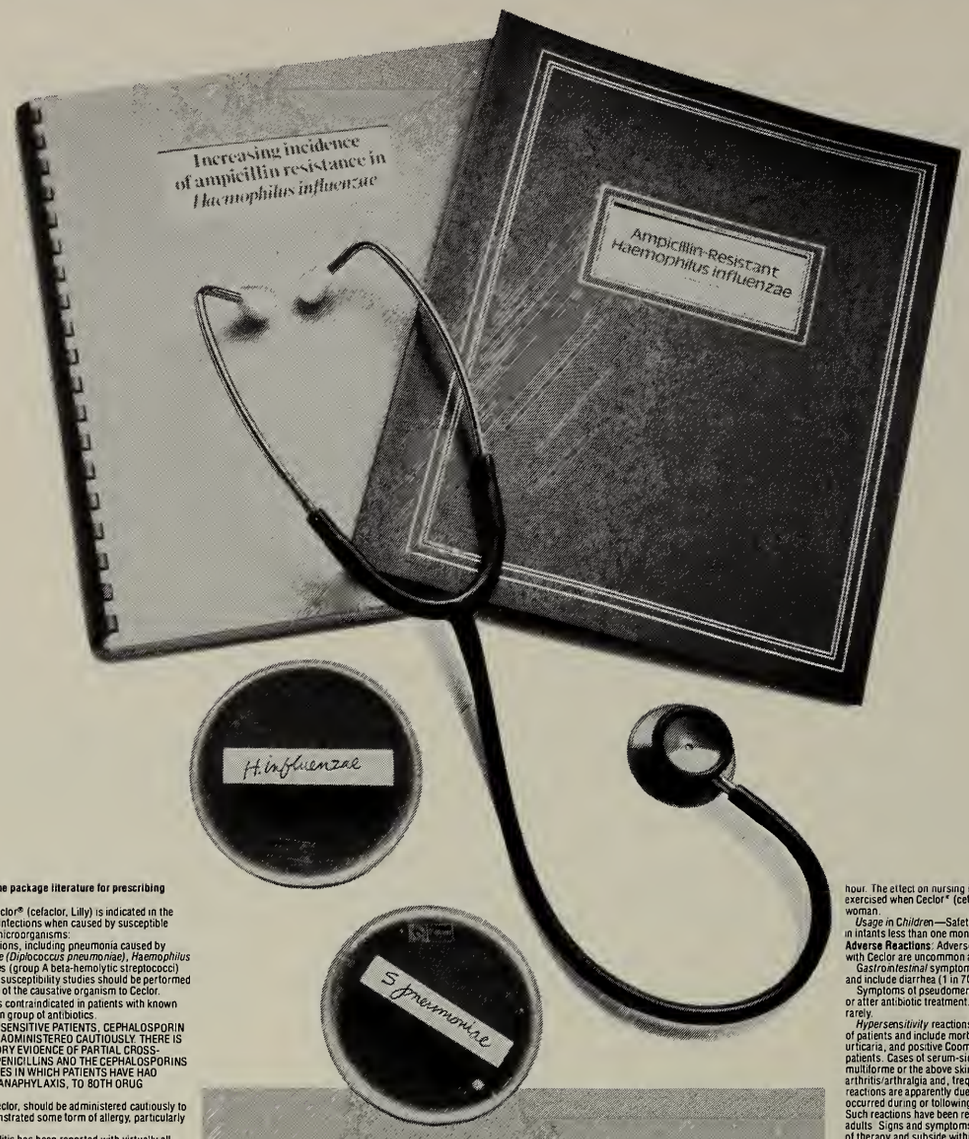
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activities; distributing educational materials and other health-related materials; even writing letters to the editors of their local newspapers or authoring a weekly health column.

But more and more are taking a second look at the more aggressive forms of communications — flyers and door-hangers; newspaper, TV and radio ads; and even billboards that let the public know that they're still in business and available. **OSMA**

Susan Porter is Assistant Editor of the **Ohio State Medical Journal.**

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and S. *pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor* (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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Carolina, Puerto Rico 00630

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Contract Medicine: The Strongest Competitor

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authorization before the commencement of specified procedures? What period of time is required to receive prior authorization? What specific procedures require prior authorization?

22. Does the contract require that the physician maintain full medical staff privileges at one or more "contracting" hospitals?

23. Does the contract obligate the physician to perform any services after the contract is terminated?

24. Does the contract define ancillary services?

25. Does the contract allow for a negotiated fee schedule to be unilaterally changed without prior notice to the physician and/or without the prior assent of the physician?

26. Does the contract limit the number of patients the physician may (or must) serve over the course of a year?

27. Does the contract require the physician to be available on a 24-hour basis?

28. Does the contract require a "contract" physician to arrange for another "contract" physician to cover during absences or vacations?

29. Does the contract refer to unspecified medical policies? Does any party to the contract have the right to unilaterally change medical policies? Does the physician have copies of the medical policies?

30. Does the physician's professional liability policy cover contractually assumed liability?

31. Does the contract require the physician to accept all patients referred under the contractual relationship?

32. Does the contract require all non-physician entities who are parties to the contract to maintain a qualified medical director?

33. Does the contract require the physician to inform patients as to whether the physician's services are covered or non-covered under the patient's health plan?

34. Does the contract limit the right of a physician to contract with any other third party?

35. Does the contract require minimum or maximum case loads?

36. Does the contract permit termination if the contractor becomes insolvent?

A final word of advice from Robinson is to have all contracts reviewed by a qualified attorney. Even this can be difficult, he adds, because, "If you find an attorney who knows anything at all about health care, most likely he or she represents a hospital or a contracting agency. A physician needs an attorney who will represent his or her interests, and his or hers alone."

Only a small percentage of the population in this state is enrolled in an alternative delivery system, indicating that the informal, one-to-one verbal agreement is still the kind of contract most Ohio patients prefer.

While contracts now are flooding the state of California — and are definitely on the rise here in Ohio — the future of contractual medicine remains uncertain. Perhaps the biggest indication as to its success or failure is not the number of physicians who choose to join these alternative delivery systems, but the number of patients who elect to sign up for membership.

According to Holcomb, only a small percentage of the population in this state is enrolled in an alternative delivery system, indicating that the informal one-to-one verbal agreement is still the kind of contract most Ohio patients prefer to maintain with their doctors. Even in California, most patients still prefer making their own personalized choice in the selection of a physician, Robinson relates.

"A lot of doctors in our state are paying a lot of money to join these things and nothing is happening (for them)," he says. "The question I always have to ask is — Where's the patients?" **OSMA**

Susan Porter is Assistant Editor of the Ohio State Medical Journal.

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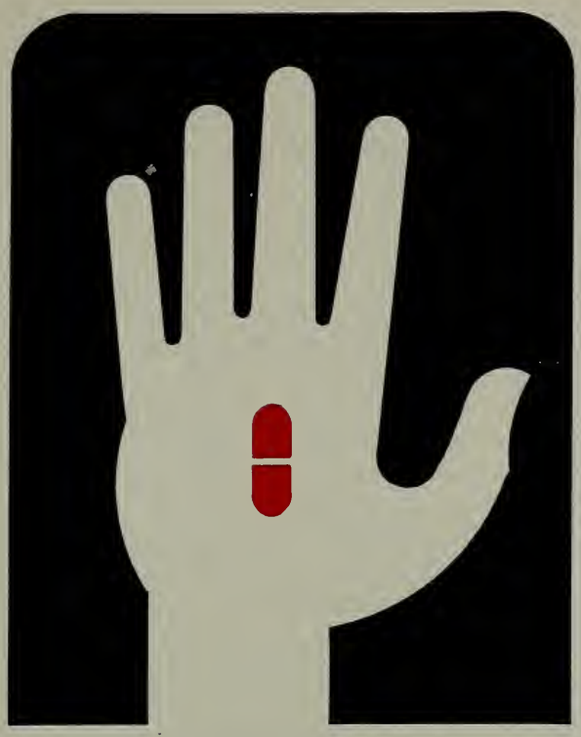
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Competition and Chemical Dependency: Taking the Lead

By Susan Porter

As long as there is money to be made on the meetings, materials and seminars aimed at the chemically dependent, programs will continue to thrive as a "big business," and more and more groups will get involved.

Whether we like it or not, competition has hit medicine like a summer tornado, upheaving every aspect of the health care industry, leaving nothing in its path untouched. And, "Whether we like it or not, we're only seeing the preliminary forms of competition — it will increase markedly over the rest of the decade," predicts Robert Niven, MD, director of the National Institute of Alcoholism and Alcohol Abuse (NIAAA) in Washington, D.C.

Dr. Niven was a key speaker in a recent symposium sponsored by the Ohio Psychiatric Association (OPA) titled, "Alcoholism and Chemical Dependency — Update 1984." Perhaps nowhere has competition hit harder than in the area of chemical dependency, he says, where a growing number of health care professionals and paraprofessionals are leading workshops, conducting seminars and sponsoring treatment programs aimed at the alcoholic.

Like competition, itself, the theories behind the programs now being used to treat substance abusers have evolved over a number of years, originally surrounded by attitudes of distaste and unprofessionalism, and only recently moving into the realm of acceptability. Just as many felt — and some continue to feel — that the practice of medicine is above price wars and advertising; some physicians held — and still hold — that the alcoholic or drug abuser creates his or her own problems — suffers from a moral disease, rather than a physical disease, and thus is beyond (or beneath) medical treatment.

"Even among the medical profession today," Dr. Niven says, "many of my colleagues still don't accept the notion of alcoholism as a disease; rather, they feel it is simply a matter of willpower. This lack of acceptance is evidenced in our practices, in our medical schools and in our continuing education programs."

Third leading cause

Yet alcoholism is the third leading cause of death in our country, with at least 15 million Americans suffering from this "denied disease," points out the Winter 1984 issue of *Cincinnati Medicine*. At a recent meeting of the Academy of Medicine in Cincinnati, Conway Hunter, MD, director of the Southeastern Conference on Alcohol and Drugs, told Ohio doctors that although alcoholism has reached

Future Trends in Chemical Abuse

What will the future bring to the increasingly competitive field of drug and alcohol abuse treatment? Robert Niven, MD, director of the National Institute of Alcoholism and Alcohol Abuse (NIAAA), says physicians need to be aware of the following trends and issues that are likely to arise over the next decade:

- As more and more third-party payers demand proof of expertise in dealing with patients with drug and alcohol abuse problems, a credentialing process for doctors involved in treatment programs may become necessary. This could lead to the question: should chemical dependency be a subspecialty of medicine; if so, under what specialty should it fall: psychiatry, preventive medicine, family medicine or some other specialty?
- There is likely to be an increase in malpractice claims due to underdiagnosis or misdiagnosis of the alcoholic patient. People who are victims of alcohol-related accidents are getting increasingly vocal, and "It's only a matter of time before some doctor gets sued," Dr. Niven says.
- Numerous ethical questions already are arising surrounding chemical dependency. They include: Should alcohol abusers be *forced* to undergo treatment? Should punishment be a part of the treatment? Should those with alcoholic cirrhosis of the liver be eligible for liver transplants?
- "Turf disputes" are likely to escalate and disciplinary boundaries become less clear and there continues to be an oversupply of health care professionals in this area.
- As health-care costs continue to stay at the forefront of government and public debate, a rationing of care to the alcoholic or drug abuser is likely to result. If physicians don't get involved, groups outside of medicine may soon be deciding who gets what care and what kind of care they will receive. **OSMA**

epidemic proportions in this country, physicians have been slow to recognize it as an illness.

It wasn't until the 1950s, says Dr. Niven, that the problem of alcoholism gained the attention of both the federal government and organized medicine, resulting in the founding of NIAAA. During the 1970s, the public's awareness of the problem increased as people "began to accept the notion that alcoholism treatment was worthwhile and appropriate," including business and industry, which "came to the conclusion that it actually saves money to identify and treat employees with alcohol problems," says Dr. Niven.

What has followed, therefore, has been an "information explosion," he says, with "a tremendous increase in the number of meetings, materials, educational and treatment programs aimed at the alcoholic. Many of these were developed by health care professionals outside of medicine, such as psychologists and social workers. "In this respect, medicine, including psychiatry, was behind," Dr. Niven says.

In many respects, some psychiatrists and other physicians still are behind in their knowledge, attitudes and treatment of those who suffer the physical, psychological and social effects of chemical dependency, he continues. Much of the problem revolves around the fact that until very recently, little was offered in the medical school curricula regarding the cause or treatment of alcoholism or drug abuse. Fortunately, this is changing.

For instance, at the Ohio State University, all first-year medical students are required to take a five-week course introducing them to the disease-concept of alcoholism, according to Jeptha Hostetler, PhD, associate professor of preventive medicine at OSU. Hostetler, who also addressed the OPA last March, says students in the course also are required to attend an open meeting of Alcoholics Anonymous and to write a detailed report of the experience.

OSU medical students also may elect to take a four-week "mini-module" on the impaired professional and the personal drug and alcohol abuse problems physicians suffer. The course goes beyond professional concerns.

"There already is a small group of medical students at OSU who are recovering alcoholics," Hostetler told OPA members at the seminar. "We need to train future physicians not only to deal with patients with alcohol abuse problems but to deal with these problems, themselves."

Other electives offered third and fourth year medical students at OSU include one-month rotations in alcohol and drug abuse treatment facilities, both in Central Ohio and around the country. In addition, first-year psychiatry residents take a 10-week course learning to share their knowledge in hospital rounds, inservice workshops and educational programs for other staff members.

Other medical schools in the state also are getting involved, and at Wright State University School of Medicine in Dayton, students are taking their expertise out into the community. One such effort is the Weekend Intervention Program which "helps problem drinkers confront their destructive behavior and starts them on the road to recovery," according to William D. Sawyer, MD, dean of the school. The program has been expanded to include a Teenage Intervention Program, assisting youth

in the early stages of drug abuse problems.

"Medical students participate actively in the intervention programs to learn about alcoholism and drug abuse and how to deal with it as health professionals," Dr. Sawyer says. "Other students in the university also participate as volunteers or paid counselors or as part of a formal course."

Dr. Sawyer adds that the school of medicine is involved in these programs because, "The abuse of drugs and alcohol affects the well-being and health of our population. The Wright State University School of Medicine is committed to education, to research and development, and to services that train our students and that seek the causes of and solutions to our nation's health problems. The abuse of alcohol and drugs ranks high among those problems."

A need to evaluate

Although Ohio medical schools now recognize that substance abuse is a health care problem that future physicians must help to solve, too many of today's doctors are still behind in their knowledge and attitudes regarding its causes and cures, says Dr. Niven. "The acceptance of alcoholism as a disease is not universal," he says. "Is alcoholism sick or bad — is it a physical disease or a moral disease? — this is still a growing controversy."

Even without the aid of the medical profession, programs designed to treat the alcohol and drug abuser have mushroomed and are now considered "big business," according to Dr. Niven. Unfortunately, not all of the help that is being offered is necessarily healthy.

"It is appalling what some people are passing off as proven, longstanding treatment that simply is hypothesis or theory," says Dr. Niven. "Some philosophies and models of treatment have only circumstantial evidence to support their effectiveness."

It is here that physicians can offer the most assistance and must take the lead in the fight against drug and alcohol abuse. "There is a real need to evaluate some of these treatment programs . . . Much of this needs to be critically examined."

Psycho-social research is an important aspect of the evaluation process and is one area where psychiatrists and other physicians can be most effective. "This involves the matching of patients with certain characteristics to certain kinds of treatment programs. We need to know which patients do best in which kinds of programs," he says.

In many respects, some psychiatrists and other physicians still are behind in their knowledge, attitudes and treatment of those who suffer the physical, psychological and social effects of chemical dependency.

More research also needs to be done in the "hard sciences" — biochemistry, genetics, etc. — in an effort to better understand how the disease is caused and how it can be treated. "A lot of new scientists have been drawn into alcohol research because the stigma has declined — it is now seen as a good, hard, worthwhile endeavor."

But both alcohol treatment and research efforts remain underfunded, says Dr. Niven, and need the support of the medical profession in order to draw more monies both from private and public sources. "We in the medical profession need to become better advocates than we have been," he says.

Physicians also need to learn better how to work with other non-medical professionals in this area, including social workers, psychologists and rehabilitation counselors. "While psychiatrists and other doctors in hospitals will see the more difficult and complicated drug and alcohol cases, the less complicated cases will continue to be treated by non-medical staff, simply because it's more cost effective," says Dr. Niven.

Finally, physicians need to encourage the development of more educational programs related to chemical abuse, not only in medical schools but in continuing education programs, as well.

"Treatment problems are very solvable," says Dr. Niven. "The research that is going on today will give us new insights and new treatments, including some pharmacological treatments that will aid in complications of alcohol abuse, such as cirrhosis of the liver."

What is not so easily solved is the problem of misinformation and the unproven treatment programs that may continue to develop without the involvement, guidance and leadership of the medical profession. As long as there is money to be made on the meetings, materials and seminars aimed at the chemically dependent, programs will continue to thrive as a "big business" and more and more groups will get involved in the effort.

"If doctors wish to see an outcome of the competition process they favor, they will have to become involved in it," Dr. Niven warns. "If we don't do it ourselves, someone else is going to do it for us.

"Psychiatry already has contributed a lot to the field of alcohol abuse treatment," he continues, "but there's a lot more we need to contribute."

Unless physicians get more active and do a better job of communicating their efforts, not only will they fail to take the lead in providing treatment. "We're going to get left behind, altogether," he concludes. **OSMA**

Susan Porter is Assistant Editor of the Ohio State Medical Journal.

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THE EXTRA MILE

Where Do You Go From Here?

By Rebecca J. Doll

Marketing. Competition. Consumer. Alternate delivery systems. Provider.

Just a few short years ago, these words held little significance within the medical profession. It was enough to be a good doctor, to practice high quality, cost effective medicine. You didn't have to think about marketing your practice. Competition with your colleagues was unthinkable. Private, fee-for-service medicine was the norm. There were no urgent care centers, or health maintenance organizations to contend with. You were a doctor and you treated patients. And while some physicians maintain that the status quo is still an option, it is fast becoming an obsolete one. The successful doctors of tomorrow will have little choice but to compete. They may have to target their practices to a specific audience. They may have to increase their patient communications efforts. They may have to learn how to contract with businesses to provide care to employees. They may have to improve their written patient materials and may have to develop entirely new methods of marketing their practices to meet the needs of the community.

All this will take a special effort on the part of these forward thinking doctors. They will have to take that extra step, go that Extra Mile — if they are to succeed.

The OSMA has taken the lead in this effort — to help its members go that Extra Mile. Through its Committee on Communications, the OSMA has developed the Extra Mile Program with the goal of helping



Becky Doll, OSMA's Director of Communications, discusses the Extra Mile program at a recent AMA seminar on Marketing held for Ohio physicians.

"It used to be that just being a good doctor was all it took to maintain a healthy medical practice. Unfortunately, in today's environment, that isn't always the case."

individual physicians and county medical societies develop marketing/communications programs that will be successful in today's environment.

According to William Dorner, Jr., MD, chairman of the Committee on Communications, the program has been divided into two parts, one aimed at County Medical Societies and one at the individual physician. "The goal of the county medical society program is to assist counties in developing projects that will inform the public as to the health services available within a given county and to improve the public image of the medical profession within that county and as a whole," Dr. Dorner explains.

He cites a recent public opinion survey conducted by the American Medical Association, which indicates a widening gap between the public's positive image of their own physicians and their more negative image of the profession as a whole. The difference between these views suggests that the public image of physicians is strongly influenced by factors other than personal experience. Although various factors contribute to this diversion of viewpoints, one notable factor is, no doubt, the media.

"The media have shown themselves to be capable of shaping and swaying public attitudes toward a number of institutions," Dr. Dorner says. "For organized medicine, the message is clear. As a group, we must become more involved with the media and more involved with the community so that the true story of medicine is told. And programs on the local level are critical to our success."

To assist counties in developing programs that will achieve these goals, the Department of Communications has developed a kit for the County Medical Society which contains *specific* guidelines on how to start media and community relations programs on the local level. Included in the kits are descriptions of dozens of projects from which the county may pick and choose, depending upon local needs and the willingness of the county society to commit time and energy to the projects.

"You won't find a lot of theory and philosophy in this kit," Dr. Dorner says. "I think we've just about been theoried to death. What we need now are some concrete, hands-on projects that can help us project the image we want to project within the community. This kit does just that."

Samples of projects contained in the kit include how to develop a total media relations program, how to sponsor local health fairs and seminars, how to develop a newspaper supplement, how to develop medicine/business coalitions, how to develop a consumer directory that informs the community what's available within the county in terms of medical care and how to get publicity for your county society's events.

Also available is a kit for the individual private practitioner which contains a wealth of information on everything from how to develop patient newsletters to participating on local radio programs.

"Some of the ideas contained in this kit may be appropriate for your practice, some may not. But this kit will give you an idea as to the wide variety of choices available to you in communicating with your current patients, potential patients and becoming more involved with the community and the media," Dr. Dorner says.

"It used to be that just being a good doctor was all it took to maintain a healthy medical practice. Unfortunately, in today's environment, that isn't always the case. A lot of people have been coming between us and our patients — government, third party payers, insurance companies and the influence of the media," Dr. Dorner points out. "If we're going to maintain our practices and continue to provide high quality medical care for our patients, we are going to have to make a special effort to improve our communications with our patients so we'll be able to compete with the information they receive from other sources — some of which may not be

Those Who Have Already Gone "The Extra Mile"

The Communications Committee has been working with the Department of Communications over the past year to determine the climate of competition in Ohio, and what the Ohio State Medical Association can best do to help its physician-members survive in that climate. "The Extra Mile" program has been a result of that study. Listed below are the members of the committee who have helped in making this project possible.

COMMITTEE ON COMMUNICATIONS

William Dorner, Jr., Chairman	**Lance A. Talmage**
Akron	Toledo
A. Robert Davies	**Richard C. Wamsley**
Troy	Cleveland
Christopher Kircher	**James W. Wiggin**
Cincinnati	Mansfield
James F. Quilty, Jr.	**John Thomas**
Columbus	Wooster

accurate."

Dr. Dorner adds that the Extra Mile program has not been designed to teach physicians and county medical societies everything there is to know about how to market their medical practice or a medical society. What it will do, however, is help you develop marketing and communications skills in a very important, very specific area — physician/patient communications.

"This may mean developing new programs within your offices or it may mean participating in community health projects and media interviews. And the best part of the program is that the OSMA is available to assist you in developing your specific programs," Dr. Dorner emphasizes.

"What we need now are some concrete, hands-on projects that can help us project the image we want to project within the community."

The Extra Mile kits, which were unveiled at OSMA's annual meeting held recently in Cincinnati, are available through the Department of Communications.

"I encourage all county societies and members who are experiencing practice problems to obtain these kits. They may not provide answers to all of your problems, but they will get you started in the right direction and will give you a better understanding as to what is available to you in terms of programs and assistance." **OSMA**

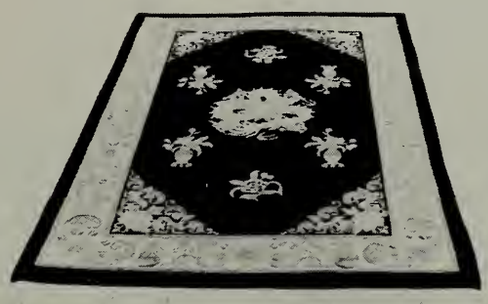
Rebecca J. Doll is Director of the Department of Communications, and an Associate Executive Director of the OSMA.

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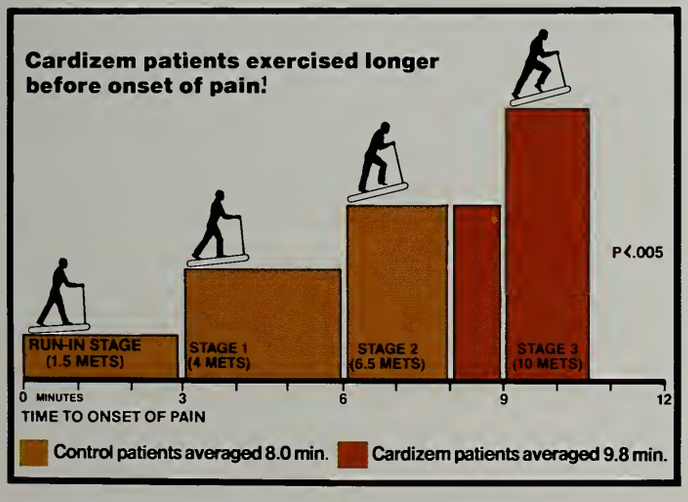
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†This study is a report from one center in a multicenter study.

Therapy with Cardizem produced a low incidence of side effects.

In placebo-controlled trials (222 patients) conducted in the United States, the incidence of adverse reactions reported during Cardizem therapy was not greater than that reported during placebo therapy.

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- Nausea 2.7%
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- Arrhythmia 2.0%
- Headache 2.0%
- Rash 1.8%
- Fatigue 1.1%

Other reactions reported infrequently (less than 1%) are listed in full prescribing information on adjacent page.

References:

1. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. *Chest* 78 (July suppl): 234-238, 1980.
2. Schroeder JS, Feldman RL, Giles TD, et al: Multiclinic controlled trial of diltiazem for Prinzmetal's angina. *Am J Med* 72:227-232, 1982.

*Please see adjacent page for full prescribing information.

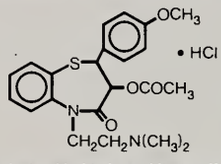
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PROFESSIONAL USE INFORMATION

cardizem™
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM™ (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate/blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent as a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents. CARDIZEM has been effective in short-term controlled trials in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness is incomplete.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (four of 959 patients for 0.42%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** There has been a single report in a patient receiving 120 mg of diltiazem tid of marked transaminase elevation (SGOT 4500, SGPT 2300) accompanied by hyperbilirubinemia (to 3 mg%), occurring after four days of treatment. The enzyme abnormalities resolved entirely, and enzymes were nearly normal a week after cessation of treatment. No rechallenge was carried out, but the patient had no evidence of viral hepatitis and received no other drugs but isosorbide dinitrate.

   No other similar liver injury has been reported in clinical trials, but marketing experience in Europe has resulted in a rechallenge-confirmed instance of hepatocellular injury. However, it should be noted that there have been further episodes of raised transaminases in the absence of diltiazem in this patient, so that the relationship to diltiazem of the abnormalities is not completely clear. Other instances of transaminase elevation have been reported in Europe, but their relationship to the drug is uncertain.

PRECAUTIONS

General. CARDIZEM is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities; the effect of diltiazem on serum digoxin levels has not been examined. The safety of the combination of CARDIZEM and beta-blockers or digitalis is currently being investigated in well-controlled studies.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded. Experience with an added beta-blocker is also extremely limited.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

In addition, the following have been reported infrequently and represent occurrences which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are nausea (2.7%), swelling/edema (2.4%), arrhythmia (2.0%), headache (2.0%), rash (1.8%), and fatigue (1.1%). In addition, the following events were reported infrequently (<1.0%). The order of presentation corresponds to the relative frequency of occurrence.

Cardiovascular:	Flushing, congestive heart failure, bradycardia, hypotension, syncope, pounding heart.
Central Nervous System:	Drowsiness, dizziness, lightheadedness, nervousness, depression, weakness, insomnia, confusion, hallucinations.
Gastrointestinal:	Vomiting, diarrhea, gastric upset, constipation, indigestion, pyrosis.
Dermatologic:	Pruritus, petechiae, urticaria.
Other:	Photosensitivity, nocturia, thirst, paresthesias, polyuria, osteoarticular pain.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

Experience in 959 patients taking oral doses of CARDIZEM resulted in three cases (0.31%) of second-degree AV block and one case (0.10%) of third-degree AV block at doses of 240 to 360 mg daily.

In rare instances, mild to moderate transient elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK have been noted during CARDIZEM therapy. A single incident of markedly elevated liver enzymes associated with symptoms was reported in a patient taking 360 mg per day for four days. Drug was discontinued and enzymes normalized within 1 week.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experiences with oral diltiazem have not been reported. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually to 240 mg (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. The effectiveness and safety of dosages exceeding 240 mg per day are currently being investigated. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents.

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

CARDIZEM 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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Organized Medicine's New Partnership

By Karen S. Edwards

At last month's Annual Meeting, a special hospital medical staff section was created by the OSMA House of Delegates. The decision was not a frivolous one. In fact, it was a very important one.

A couple of years ago, Paul Starr, an esteemed sociologist, wrote a Pulitzer Prize-winning book entitled "The Social Transformation of American Medicine" which made the public in general (and the medical profession in particular) sit up and reevaluate the direction American health care was headed.

"Doctors and hospitals may be on a collision course," Starr warned us, "as doctors invade institutional services and hospitals invade ambulatory care."

The prediction seemed as far-fetched as the four-year old GMENAC report which told us that by 1990, the US would be inundated with physicians. But time seems to be on the side of both GMENAC and Starr.

Physician numbers are increasing . . . and so is the growth of for-profit hospitals and multi-hospital systems. Suddenly, physicians are in a brand-new, brave new world of competition and contractual medicine . . . and, in fact, by the end of 1981, approximately 191,000 physicians had some contractual relationship with hospitals or other health care facilities.

As the number of hospital-based physicians increases, it stands to reason that hospitals are beginning to exert considerable influence on the way medicine is being practiced in this country. Yet hospitals are struggling, too, in the same competitive environment that has stunned the medical profession.

It is this gradual shifting of roles, the blurring of traditional lines that may be causing the medical profession's biggest headache to date. As the hospital gains more and more prominence as a health-care provider, and as more and more physicians become hospital based, the collision which Starr mentions in his book does seem inevitable.

For this reason, the American Medical Association (AMA) began to explore the idea of forming a special section within organized medicine's structure which would take a look at some of the problems that are being created for hospital medical staffs, and attempt to solve them creatively and, more important, collectively . . . as a profession.

Following the 1982 Interim Meeting, in which the AMA's House of Delegates voted to create a special Hospital Medical Staff Section (HMSS), a 10-member steering committee (which included Ohio State Medical Association member, Charles M. Klein, MD, Toledo) was able to get the project off the ground and, last June, the AMA-HMSS held its inaugural meeting.

Walter A. Reiling, Jr., MD, an OSMA member from Dayton, was elected to the new section's Governing Council, and a number of representatives from Ohio hospital medical staffs were present at that first meeting.

The group is hopeful of what it can accomplish.

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"The major problems facing medicine today are economic in nature, and government, industry and third-party payers are focusing more and more of their attention on hospitals. Of course, the hospital-physician interface is the medical staff, so it is important that we organize ourselves now and, together, attempt to meet the issues as they are raised."

nature," says Dr. Reiling, "and government, industry and third-party payers are focusing more and more of their attention on hospitals. Of course, the hospital-physician interface *is* the medical staff, so it is important that we organize ourselves now and, together, attempt to meet the issues as they are raised."

Dr. Reiling is quick to praise the AMA for forming its medical staff section.

"The AMA anticipated the problems before they occurred — and found a way to handle them."

According to Dr. Reiling the section provides a forum for representatives from all the nation's hospital medical staffs to meet and exchange discussions on common problems.

"Because each hospital has the right to send one representative, the section has the potential to expand to 7,000 members," says Dr. Reiling, although only 500 to 1,000 members are currently participating.

"The section also allows individual medical staffs direct input into AMA policy," says Dr. Reiling.

Some of the issues which the AMA-HMSS are, and will be addressing include:

- Defining the relationship between the hospital medical staff and the hospitals' governing bodies
- Non-physician providers
- Physician oversupply and
- Alternate health-care systems.

Whether or not the group will make major strides at home, however, is going to depend to a great extent on the local and state organizations, as most of the problems that are being discussed in the new section are, ultimately, going to have to have local solutions.

The AMA has been encouraging state associations to form their own hospital medical staff sections, and it is with this encouragement that Ohio looked into the project early last year.

William Dorner, Jr., MD, Akron, in cooperation with the Summit County Delegation, introduced a resolution before the 1983 House of Delegates, requesting the formation of such a section. In remarks made prior to a meeting on the AMA-HMSS, Dr. Dorner re-emphasized the need for a similar section at the state level:

"The relationship between the hospital and the medical staff can either grow strained or stronger, depending on the resolve of both parties to cooperate in this new environment. I believe the opportunity of direct representation of the hospital-medical staffs in the House of Delegates, both at the AMA and OSMA level, will give the hospital medical staff issues the sort of visibility that is necessary to have the problems confronted and hopefully resolved. Certainly, at a minimum, we should understand the potential power of this new base for support of the issues of organized medicine."

Despite favorable reaction to the Resolution, the House was unable to consider it last year, as the resolution was submitted too late for publication in the *Journal.* (Since it would have technically changed the Association's by-laws, the resolution would have had to be printed three months prior to the meeting of the House.)

The 1983 House was not about to ignore it, however, and it made a recommendation to the OSMA Council that a Committee on Hospital Medical Staff Section be formed.

Then-President S. Baird Pfahl, Jr., MD, appointed a steering committee, chaired by Dr. Dorner, to get the project off the ground.

In March, invitations were extended to all Ohio hospital chiefs of medical staffs (as well as to those physicians who attended the AMA-HMSS meetings from Ohio), requesting their attendance — and input — at a meeting, held to discuss the proposed OSMA-HMSS.

The meeting was well attended, and afterwards, the committee prepared its recommendations to put before the House.

When the House finally met last month in Cincinnati, the resolution, recommending the formation of an OSMA-HMSS was adopted.

Just what it will mean for Ohio medicine is difficult to judge at this point. There are still a lot of issues that need to be worked out. Yet, in an atmosphere that has been charged with negativism, it is a positive step for organized medicine to take. It creates an environment of understanding, cooperation and negotiation that can only strengthen medicine, allowing everyone in the system to emerge as "winners."

With this new partnership — at both the state and national levels — it is hoped that the collision between hospitals and doctors, which Paul Starr so ominously predicts, can be avoided — or at least detoured.

An informed, united and strengthened medical staff may be just what the doctor ordered for today's competitive and changing environment. But only time will tell.

OSMA

There are still a lot of issues that need to be worked out, yet it is a positive step for organized medicine to take.

Karen S. Edwards is Executive Editor, The Ohio State Medical Journal.

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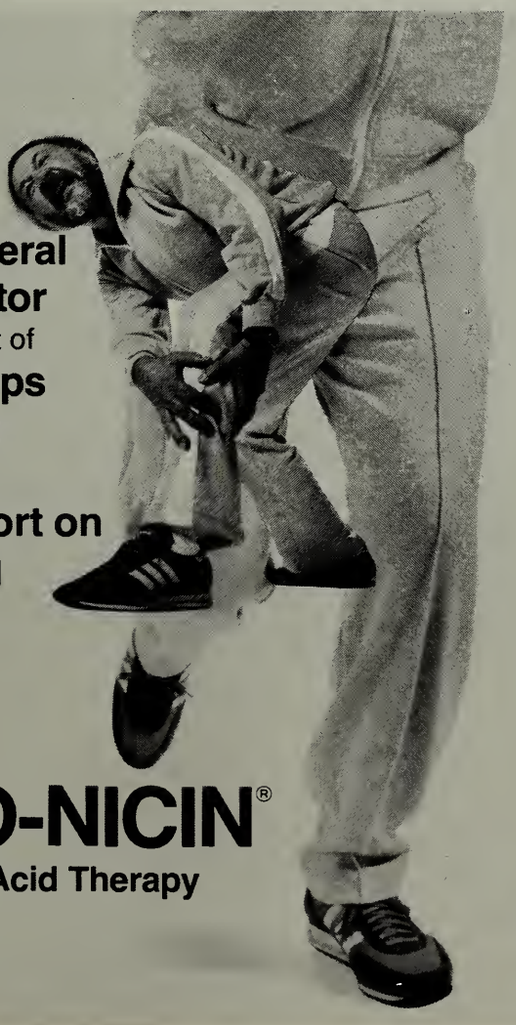
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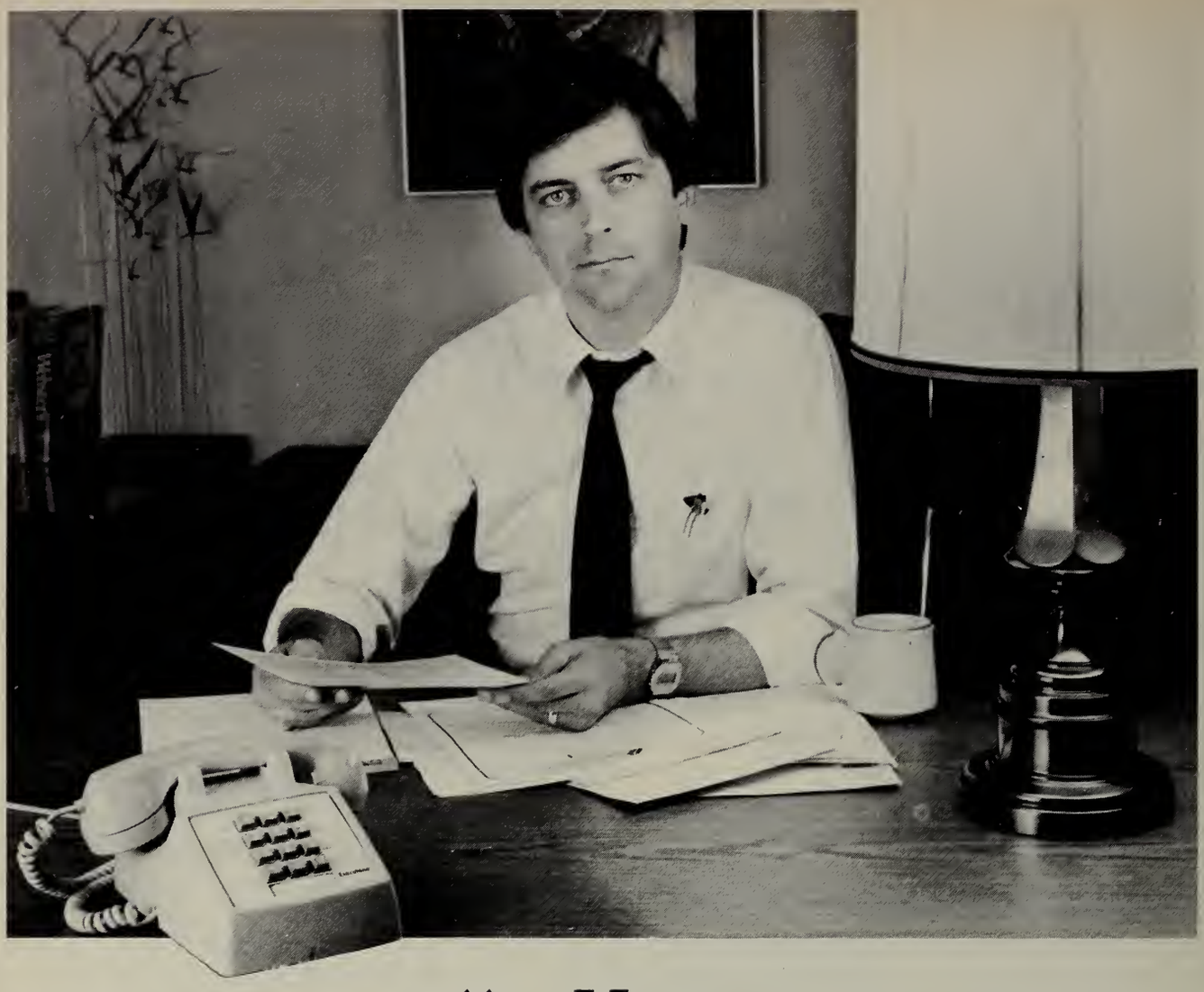
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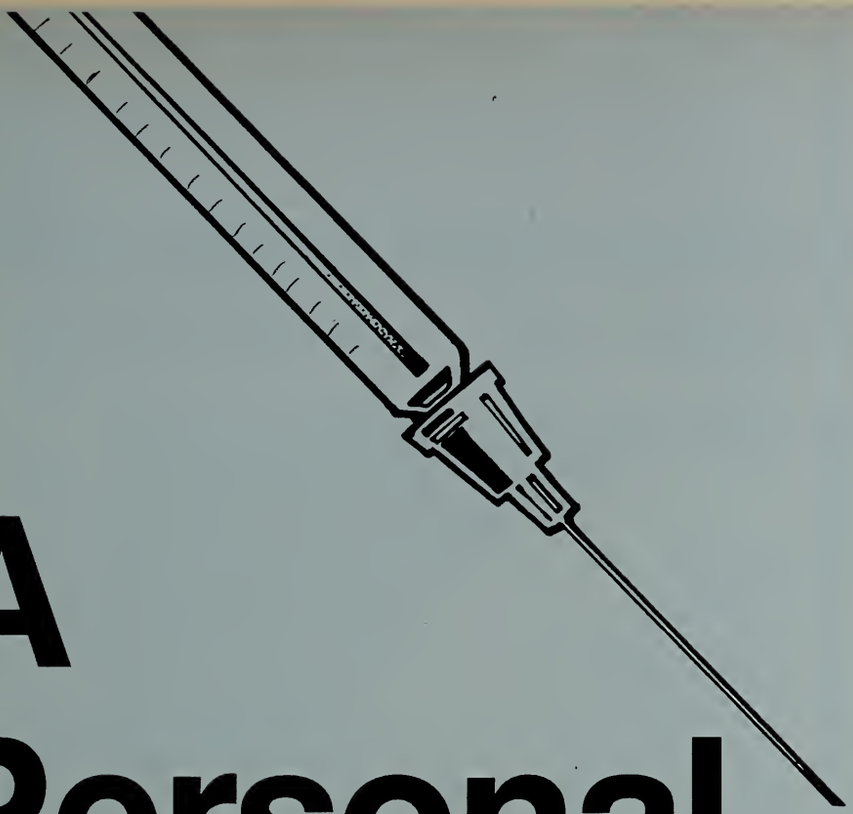
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A Personal Nightmare

By Carol Wright Mullinax

The problem began in medical school. "I had never learned how to handle stress," he says. Even in his worst moments, he admits, "I had no idea I was a drug addict . . ."

Going "public" with a problem is nothing new in our society. The airwaves and bookstores are filled with private subjects which have been brought into the public domain. There are advantages: fame, however fleeting, and sometimes, fortune.

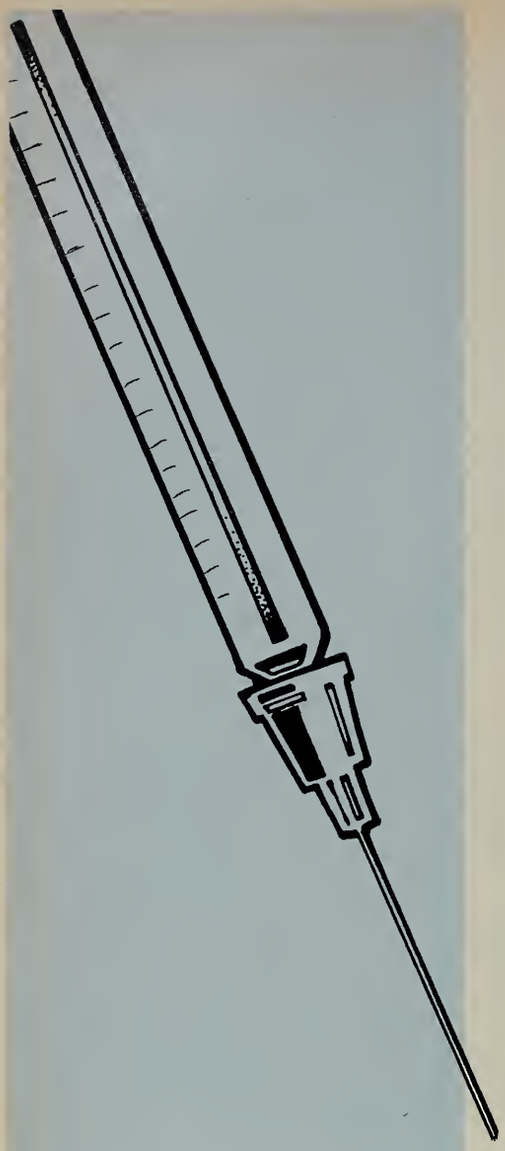
But there are drawbacks as well. Holding yourself out for public scrutiny is an idea which usually sounds better in the abstract — especially if the story you have to tell is very personal and very painful.

But five years ago when Patrick Reilly, MD,* an Ohio pediatrician, sat down to write a book about his 14 year struggle and eventual triumph over prescription drug addiction, he made the decision that the revelation was worth the risk. He felt his book could have an impact on people — especially physicians — who faced similar problems with drugs. "I wrote this book to show people 'This is a disease; it is treatable.' "

Dr. Reilly knew for a fact that public testimonies could help. Betty Ford's much-publicized drug and alcohol problem and subsequent treatment had been one of the triggering factors which made him come to grips with his own problem and enter a drug treatment program.

Although there has been growing recognition in recent years of the problems physicians face with prescription drugs, Dr. Reilly says his problems with drugs really began immediately before medical school. "I had never learned how to handle stress," he says, and the impending four years of medical school created more pressure than he could handle. Continuing bouts of anxiety and sleeplessness sent him to his family doctor for help. The physician prescribed Valium. "It was magic," Dr. Reilly says. "All my symptoms disappeared."

Once in medical school, the anxieties increased, but so did the drugs. Pharmaceutical detail men kept medical students supplied with all



"For the first time in 14 years, I had the freedom to choose not to take a drug."

types of drugs free-of-charge. A marriage halfway through medical school, a residency and setting up a practice all added to the pressure, but, Dr. Reilly says, there were always drugs to fall back on — in increasing quantities.

During the mid-seventies, after he had been in practice a while, Dr. Reilly sought the help of a psychiatrist because, he says, he was worried and embarrassed by the amount of drugs he was taking. The psychiatrist explained that he took drugs because he was depressed and prescribed additional drugs.

Things could have continued this way indefinitely, Dr. Reilly says, were it not for the fact that his escalating drug usage was having an effect on his practice of medicine and his personal life. Blackouts, panic attacks, near-misses in diagnosis and treatment and a deteriorating home life made him realize that something must be done. Finally, he made the decision to enter a drug treatment program.

During the intensive two-month treatment which included private counselling as well as group therapy, Dr. Reilly examined the reasons behind his drug addiction and began to learn how to live without drugs. The treatment was a success. Dr. Reilly says that when he left the program, "For the first time in 14 years, I had the freedom to choose not to take a drug."

But he realizes that slipping back into his old habits is an everpresent danger. His thrice weekly visits to a support group have helped him over the rough spots of reestablishing and redefining his life. He also has become involved in the OSMA's Physician Effectiveness Program to help identify and aid physicians with similar problems.

Because of his experiences, Dr. Reilly is very interested in the relationship between physicians and drugs. Although he is quick to admit his own complicity in his drug addiction ("I never learned non-chemical coping"), he says that all physicians are at special risk for problems with alcohol and drugs.

The biggest contributing factor, he says, is that physicians suffer from the "Titanic Syndrome." They think they are invincible. Even in his worst moments, he says, "I had no idea I was a drug addict."

This feeling of invulnerability, coupled with easy access to drugs and the stress of the job, make physicians more susceptible to drug and alcohol problems than the average person. Recent studies show that drug addiction is 30% to 100% more common among physicians than the general population. Dr. Reilly would like to see this problem addressed in medical school.

He would also like all physicians to take a long, hard look at their attitudes toward drugs. Careless and lazy physicians, he says, can be the perpetuators of drug problems among patients. Dr. Reilly cites his own experiences with physicians who contributed to his problems with drugs.

"Physicians need to learn more about the effects of alcohol and drugs," Dr. Reilly says, adding, "they also need to help patients find non-chemical ways of coping with their problems."

Since his graduation from the drug treatment program, Dr. Reilly has worked hard to build a new life for himself. He wrote his book* under a pseudonym in an effort to carry on his life as near-normal as possible. This is especially important since a screenplay is being written to turn the book into a motion picture. The few colleagues who do know about his problem, Dr. Reilly says, have been "very supportive."

Although he is not "proud of the fact" that he was addicted to drugs, Dr. Reilly is philosophical about what happened to him: "I had a disease, but I sought help." He's hoping his book will help others do the same. **OSMA**

Carol Wright Mullinax is Associate Director of The Ohio State Medical Association's Department of Communications.

**Patrick Reilly, MD, is a pseudonym for the author of the book* A Private Practice, *(Macmillan Publishing Co., 1984).*

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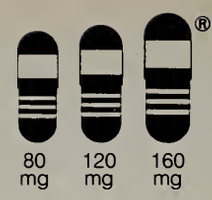


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DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Council Proceedings

March 24, 1984

A regular meeting of the Council of the Ohio State Medical Association was held on Saturday, March 24, 1984, at the OSMA Headquarters' Office, Columbus, Ohio.

Those present were: S. Baird Pfahl, Jr., M.D., Sandusky; A. Burton Payne, M.D., Ironton; David A. Barr, M.D., Lima; Herman I. Abromowitz, M.D., Dayton; Thomas R. Leech, M.D., Lima; Benjamin H. Reed, M.D., Wauseon; Donavin A. Baumgartner, Jr., M.D., Cleveland; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; Thomas P. Price, Jr., M.D., Gallipolis; D. James Hickson, M.D., Mt. Gilead; D. Ross Irons, M.D., Bellevue; Joseph L. Kloss, M.D., Akron; James E. Pohlman, Esq., OSMA Legal Counsel, Columbus; Oscar W. Clarke, M.D., Chairman, AMA Delegation, Gallipolis; Stella Brown, President, OSMA Auxiliary, Dayton; David L. Jackson, M.D., Director, Ohio Dept. of Health, Columbus.

Those present from the OSMA Staff were: Hart F. Page, CAE; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew, Esq.; Rebecca J. Doll; Gail E. Dodson; Robert E. Holcomb; David C. Torrens; Carol W. Mullinax; Eric Burkland; Michael L. Bateson; Catherine M. Costello, Esq.; Louis N. Saslaw; William E. Fry; Aristotle Hutras; Carol M. Maddy.

Dr. Pfahl called the meeting to order.

The Council discussed the February 23, 1984 action of the AMA Board of Trustees authorizing a letter to each physician in the U.S., urging him or her to freeze fees for a one-year period, beginning immediately and to continue to take into account the financial circumstances of his or her patients — especially the unemployed, the uninsured and those under Medicare — and to accept reduced fees when warranted.

The Council had before it, President Pfahl's statement of February 24, announcing to the media and the public, that OSMA will join the AMA in urging physician members to freeze their fees for a one-year period.

The Council voted unanimously to endorse Dr. Pfahl's statement.

Physicians Insurance Company of Ohio (PICO)

As Chairman of the Nominating Committee for Physicians Insurance Company of Ohio, Dr. Pfahl reported to the Council the names of nominees for the PICO Board of Directors and for the several subsidiary Boards of Directors.

Administration

The minutes of the January 28, 1984 meeting of the Council and of the Conference Call of March 15, 1984, *were approved.*

Mr. Page complimented Carol Mullinax on the excellence of her direction of the Department of Communications during the temporary absence of Rebecca J. Doll.

He also noted several recent accomplishments of the legal department, and stated that all departments are functioning at a superior level.

Dr. Pfahl reviewed discussion with individuals, groups, government and staff concerning Peer Review Organizations.

The following publications were made available to the Council: *Request For Proposal,* Health Care Financing Administration, U.S. Department of Health and Human Services (RFP No. HCFA 84-015); *Professional Review Organization Contract Proposal Manual,* American Medical Association (1984); and *Outline of Peer Review Environment,* American Medical Association.

The President then directed Mr. Mulgrew to review the proceedings at the "Bidders Conference," sponsored by the Health Care Financing Administration of the U.S. Department of Health and Human Services March 19 and 20 in Baltimore. The conference was attended by Messrs. Gillen and Mulgrew.

Mr. Mulgrew presented in detail the information from the conference and the list of the publications above, including the technical responsibility for PRO activity.

The Council then discussed the legal and financial aspects of the PRO contract.

The Council unanimously expressed the position that the OSMA not prepare a response to the Request for Proposal from Health Care Financing Administration.

The Council voted unanimously that a recommendation not to be the contractor for PRO in Ohio be brought to a Special Session of the House of Delegates in Dayton, Ohio, April 14, 1984.

The following Resolution will be presented on behalf of the Council at the Dayton meeting:

WHEREAS, The 1983 OSMA House of Delegates considered Report A as required by Resolution 12-82, "Authority for Peer Review Functions and referred it to OSMA Council with the following instructions:

"Report A be referred to Council with a report to all delegates and county presidents within 90 days of receipt of the governments' regulations and the Council's suggestions for implementation of PRO prior to entering into any contract" and

WHEREAS, HCFA mailed the request for proposal (RFP) on February 29, 1984, and mandated bidders respond with a contract offer to HCFA no later than April 27, 1984, and

WHEREAS, The Council reviewed the requirements placed upon the prime Peer Review Organization contractor and

WHEREAS, it is the belief of Council that the technical and contractual

obligations placed on the PRO contractor are a significant change from the quality reviews originally introduced by U.S. Senator Durenberger, the author of the PRO legislation,

WHEREAS, the PRO regulations and the RFP limit the PRO's ability to focus on issues of quality care, and

WHEREAS, the PRO regulations and the contractual requirements of the prime contractor mandate most of the proposed review to be made in terms of cost, and

WHEREAS, The Ohio State Medical Association believes its role to be advocate of physicians and patients in the health care system (not as an enforcer of government programs), NOW THEREFORE BE IT

RESOLVED, that the House of Delegates of the Ohio State Medical Association approve the recommendation of Council that the OSMA not offer to contract with HCFA to perform the review services required by the PRO contract.

The Council voted to honor Dr. Oscar W. Clarke, Gallipolis, for his service on the Ohio State Medical Board, and to John Burkhart, M.D., Columbus, for his service on the Ohio Occupational Therapy and Physical Therapy Board, Physical Therapy Section during the 1984 meeting of the OSMA House of Delegates.

Physicians Administrative Corp. of Ohio (PACO)

Dr. Abromowitz reported on PACO activities and announced a meeting of the PACO Board at 1 PM, Sunday, March 25, 1984.

Financial and Membership Department

Membership statistics were presented by Mrs. Wisse indicating membership well ahead of last year.

The report of the Department was presented in writing and was filed.

Treasurer's Report

The Treasurer's report was presented by Dr. Barr and was filed.

Dr. Barr then presented a slide program on OSMA finances and dues recommendations.

Auditing and Appropriations Committee

The minutes of the March 23, 1984 meeting of the Committee on Auditing and Appropriations were presented by Dr. Abromowitz.

The following recommendations of the Committee were approved by the Council:

That staff be authorized to continue payroll administration for PACO and that OSMA funds be used for this purpose.

That an investment of $25,000 in IONA be approved, the source of funds to be negotiated with PICO by the Chairman of the Auditing and Appropriations Committee.

That funds of approximately $7000 be authorized to hold a special meeting of the House of Delegates.

That the concept of changing OSMA/PACO roles be approved.

That the Auditing and Appropriations Committee operate as the building committee during the building expansion.

That the OSMA go forward with the building expansion; negotiate a construction contract with a cap not to exceed $1.2 million to finish three floors with a fourth floor plumbed and wired and, to obtain confirmed five year space commitments from PACO and the Academy of Medicine of Columbus and Franklin County.

The minutes *were adopted.*

Department of Education; Specialty Society & Meeting Management

Mr. Torrens presented the Department report which was filed.

The 1984 House resolutions were received by the Council.

Dr. Pfahl appointed Councilors to monitor the resolutions committees as follows: Committee #1: David A. Barr, M.D., Herman I. Abromowitz, M.D., Benjamin H. Reed, M.D., Carl E. Spragg, M.D. and H. Judson Reamy, M.D.; Committee #2: Thomas P. Price, Jr., M.D., Donavin A. Baumgartner, Jr., M.D., J. James Anderson, M.D. and Joseph L. Kloss, M.D.; Committee #3: Thomas R. Leech, M.D., D. James Hickson, M.D., John E. Albers, M.D. and D. Ross Irons, M.D.

Department of Government Relations

Mr. Fry presented the written report of the Department and late developments since it was prepared. The report was filed.

Mr. Fry reported on various Omsbudsman services and departmental work with specialty societies.

Resolution No. 45-83: PPO's

The Council discussed Resolution No. 45-83. It was the decision of the Council to distribute the AMA Physician's Guide to Preferred Provider Organizations to comply with the terms of the resolution.

Governor's Commission on Health Care Costs

Dr. Irons presented a comprehensive report on the proceedings of the Governor's Commission on Health Care Costs.

Department of Development & Member Services

The report of the Department was presented in writing, was highlighted by Mr. Campbell, and was filed.

Mr. Saslaw related developments with regard to the OSMA students and residents activities.

He presented new publications of the OSMA Foundation dealing with ways to finance the programs of that organization.

Dr. Clarke, Chairman of the Foundation, discussed some of the current projects and asked for the continued cooperation of the Council.

AMA Delegation

Dr. Clarke reported for the AMA Delegation, which will meet on March 25 to work on the campaign of Dr. W. Jack Lewis to the AMA Board of Trustees.

Department of Health Education

Mr. Clinger reviewed the written report of the Department of Health Education. The report was filed.

Committee on Mental Health

Mr. Clinger presented the minutes of the February 12, 1984, meeting of the Committee on Mental Health.

The Council *approved* the recommendations of the Committee that the Department of Mental Health,

by way of a letter from the OSMA President to the Director of the Department, be urged to appoint a physician to the position of Commissioner of Mental Health.

A recommended statement of position on deinstitutionalization of chronic mentally ill people was referred back to Committee for clarification.

The minutes were filed.

Committee on Impaired Physicians

The March 11, 1984 minutes of the Committee on Impaired Physicians were presented by Mr. Clinger and were filed.

OSMA-ONA Liaison Committee

The minutes of the January 19, 1984 meeting of the OSMA-ONA Liaison Committee were presented by Mr. Clinger and were filed.

Department of Staff Counsel

Mr. Mulgrew reviewed the recent IRS audit.

Federal Legislative Report

Mr. Mulgrew announced participation of OSMA President, S. Baird Pfahl, Jr., M.D. and staff in a "fly-in" sponsored by the AMA on March 27 and 28 to discuss with the Ohio Delegation passing proposals for Mandatory Assignment of Medicare Benefits and a statutory fee freeze.

A number of other pending federal bills were discussed, including H.R. 4080, the National Organ Transplant Act.

Ohio State Medical Board

Dr. Clarke discussed the Ohio State Medical Board.

The Council commended him on his long service on the Board in the name of quality medical care.

Ms. Costello supplemented his remarks. She indicated that some of the recent decisions of the Board involve the required signing of nursing home records by physicians and guidelines for supervision of residents in family practice programs.

Certificate of Need

Ms. Costello presented a staff report of March 23, 1984, on "Certificate of Need," including criteria suggested by one of the task forces appointed by the Director of Health for action by the Ohio General Assembly.

NMR rules, as a part of the program, were also reviewed.

Mr. Burkland discussed the legislative aspects of the "certificate of need" developments.

The President appointed a task force to monitor developments on Certificate of Need and to assist staff in dealing with the rapid changes in the rules and the legislative proposals: John A. Devany, M.D., Toledo, Chairman; James C. McLarnan, M.D., Mt. Vernon; and from Council, Donavin A. Baumgartner, Jr., M.D., Thomas P. Price, Jr., M.D. and Benjamin H. Reed, M.D.

Department of State Legislation

Mr. Burkland presented information on a number of bills. He discussed the following:

Sub. S.B.204-co-admitting privileges for nurse midwives.

The Council voted a neutral position on Sub. S.B.204 providing the amendments submitted by the sponsor, including the deletion of co-admission language, remain a part of the bill.

Mr. Bateson reviewed Amended H.B.204-practice of pharmacy.

The Ohio State Pharmaceutical Association has dropped language relating to "therapeutic substitution."

Other proposals were presented in writing for the information of the Council.

The Council commended the State Legislative staff.

Department of Communications

Ms. Doll presented the written report of the department, which was filed.

Ms. Mullinax announced that the department is assisting county medical societies with newspaper supplements in several areas.

Department of Marketing & Field Service

Mr. Holcomb reviewed the written report of the Department and distributed the list of dates and locations for the pre-annual meeting district caucuses.

Councilor Reports

The councilors reported on activities in their respective districts.

Constitution and Bylaws

Revisions in the Bylaws of the Academy of Medicine of Cincinnati *were approved.*

General Counsel's Report

Mr. Pohlman discussed unauthorized practice of medicine by nurses.

He reviewed the Kartel Case in Massachusetts decided in favor of Massachusetts Medical Society, which bars Blue Shield from enforcing its ban on "balance billing." The decision was rendered by a Federal District Judge. The case will be appealed and the Governor of Massachusetts is introducing legislation to overturn the impact of the decision.

OSMA Auxiliary

Mrs. Brown distributed her written report and a tally of Auxiliary membership. This report included a review of the Auxiliary convention plans.

Mrs. Brown noted that this would be her last Council meeting representing the Auxiliary. The Council commended her for her loyalty and cooperation.

Ohio Director of Health

Dr. David L. Jackson, Ohio Director of Health, addressed the Council.

He discussed Certificate of Need and said the real authority is in the rule making.

He reported on work with Senator Michael Schwarzwalder's office on the Nurse Midwife Bill in order to obtain favorable amendments.

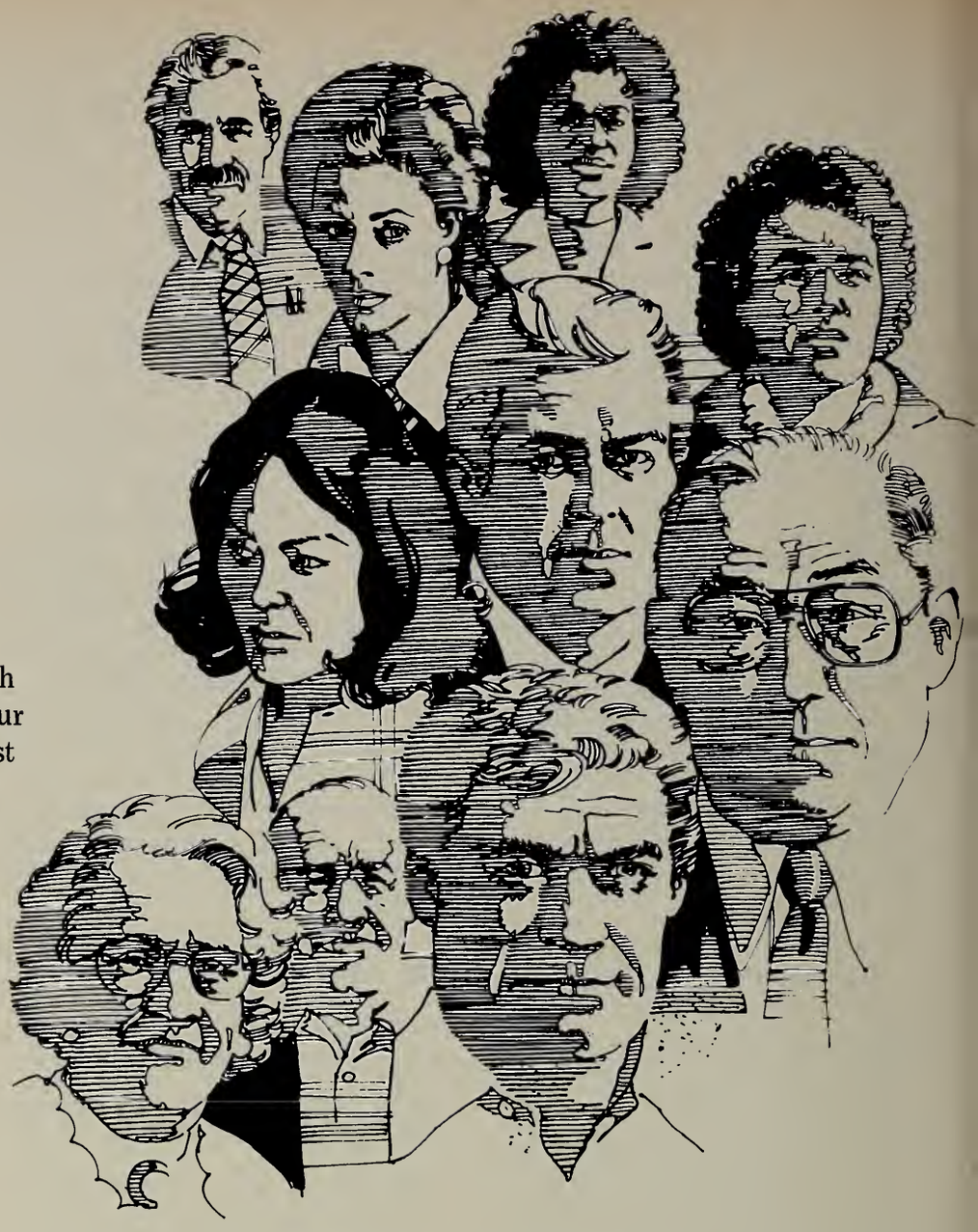
He discussed the committee established to review nursing practice and to make changes in the nurse's scope of practice. He also announced that the Coronary By-Pass Task Force is having a major meeting.

A Transplant consortium of three institutions has been established to develop guidelines on these procedures.

There being no further business, the meeting was adjourned. **OSMA**

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Exclusive Contracts

By D. Brent Mulgrew, JD, and Catherine C. Costello, JD

Editor's Note:
On April 27-28, the Forum Committee on Health Law of the American Bar Association sponsored a program on "Representing Physician Interests." Michael Yarborough, a partner in the Columbus law firm (Porter, Wright, Morris and Arthur), General Counsel to the OSMA, and Brent Mulgrew, Staff Counsel of the OSMA, discussed "Licenses, Privileges, and Other Tickets." Part of the presentation included a discussion of exclusive contracts and the most recent US Supreme Court decision: *Hyde* v. *Jefferson Parish Hospital,* US (1984). The following is an excerpt from the paper prepared for the presentation by Mr. Yarborough.

HYDE v. JEFFERSON PARISH

When analyzing exclusive contracts today, the immediate and primary focus must be upon the recent United States Supreme Court decision in *Hyde v. Jefferson Parish Hospital,* which was decided March 27, 1984. In *Hyde,* the Supreme Court denied an anesthesiologist's claim that the exclusive contract in question was an illegal tying arrangement. This long-awaited decision provides a useful vehicle to analyze the future of exclusive contract litigation in the hospital context.

Dr. Edwin G. Hyde was an anesthesiologist who practiced in Jefferson Parish, Louisiana. Dr. Hyde applied for admission to the East Jefferson Hospital medical staff and received favorable recommendations. However, the hospital board voted to deny staff privileges to Dr. Hyde due to the fact that anesthesia services to the hospital were supplied by Roux and Associates under an exclusive contract. Under the contract the anesthesiologist determines the fee for the services he renders. Patients are then billed jointly for the anesthesia services provided by the doctor and those provided by the hospital. After certain small deductions (8% of the gross), 50% of the gross receipts of the department are sent to Roux and Associates.

The district court rejected plaintiff's claim that this arrangement represented an illegal tie under the antitrust laws on the basis that the defendant hospital did not have economic power over the tying product (operating rooms) in the market within which it competed. The court relied upon the fact that large numbers of Jefferson Parish residents went to other hospitals in the New Orleans area. Thus, according to the district court, plaintiff failed to show that East Jefferson "dominated the market."

So, too, the trial court accepted the defendant's contention that the exclusive contract between the hospital and Roux was to ensure continued and quality care of the patients.[5] The court found the following factors relevant:

> Specifically the system insures twenty-four hour anesthesiology coverage, aids in the control and standardization of procedures and the efficient and less costly operation of the department; it lends flexibility to the scheduling of operations because it is not necessary to accommodate physicians with outside commitments; it permits the physicians, nurses and other technicians in the department to develop a work routine and a

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The OSMA is registered as a 501 (c)(6) corporation with the Internal Revenue Service. To maintain such standing, the Association's activities must promote the common interest of the membership rather than provide specialized services to individuals. Consequently, this column will be devoted to general legal questions of interest to the membership. Suggestions for future columns may be sent to: OSMA Department of Legal Affairs.

proficiency with the equipment they use in patient treatment; and it increases the Board's ability to monitor the medical standards exercised because there are fewer individuals involved, maintenance of equipment is simplified and equipment breakdowns are minimized by limiting use to one group of physicians.
513 F. Supp. at 540.

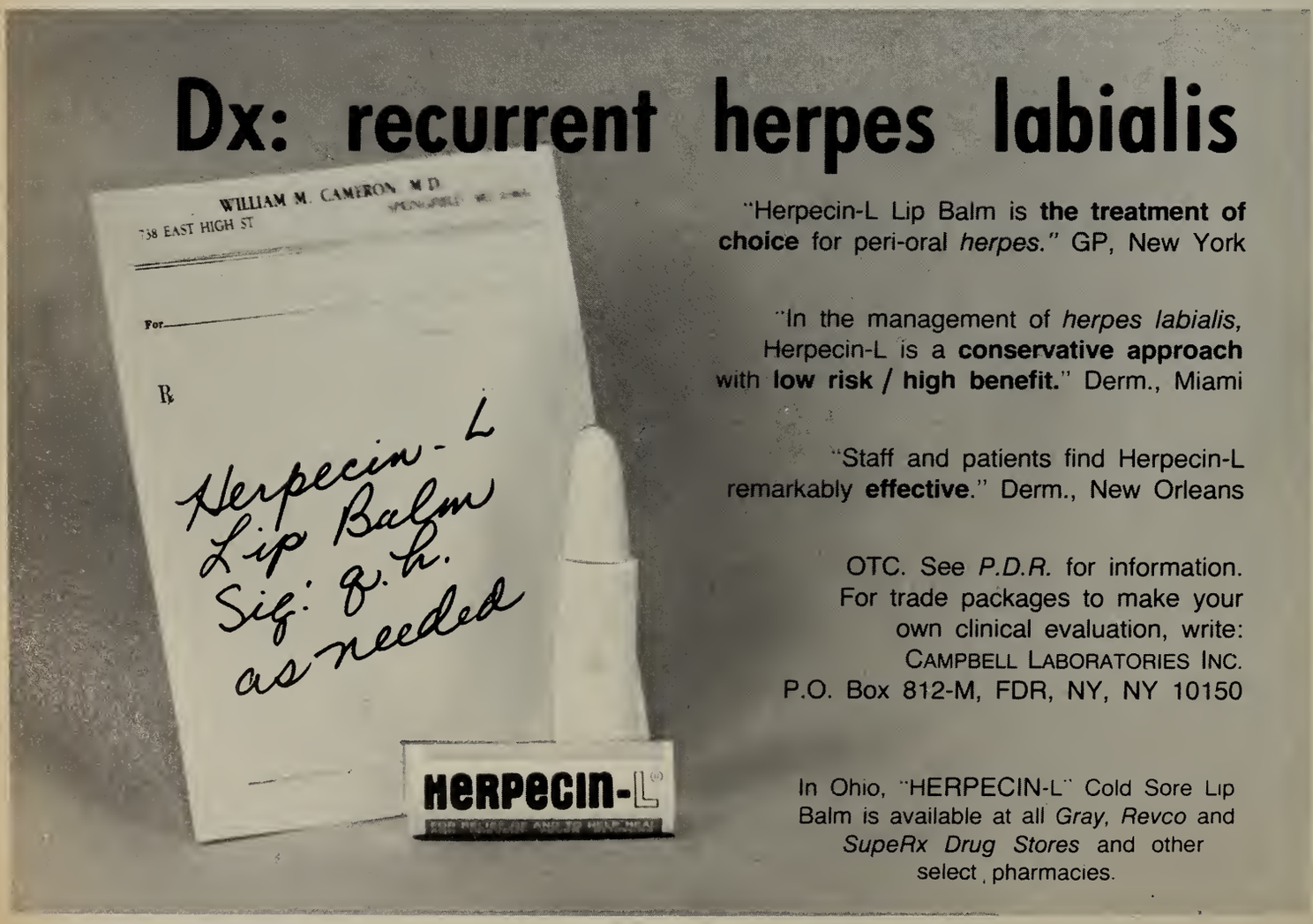
Thus, the court granted deference to the decision of the hospital and found the claimed benefits of the exclusive contract to be reasonable.

On appeal, the Fifth Circuit, primarily due to a different view of the marketplace, reversed. The Fifth Circuit initially found that no party had seriously disputed the existence of a tying arrangement.[6] Once a tie was found to exist, the court of appeals then addressed the second element of an illegal tying arrangement — whether there was sufficient economic power by the hospital over the tying product (operating rooms). Rather than requiring "dominance" over the tying product as had the trial court, the Fifth Circuit only required the plaintiff to show that there had been an "appreciable restraint on free competition in the tied product" (anesthesia services). In order to determine whether such restraint had occurred, moreover, it was necessary for the Fifth Circuit to re-examine the relevant geographic market within which the hospital operated. The appellate court disagreed with the district court's broad definition of a significant portion of the New Orleans area as the proper focus for the geographic market within which the hospital competed. The Fifth Circuit limited the relevant geographic market to the East Bank of Jefferson Parish. Based upon this limited geographic market definition, the court of appeals had no problem in finding that there had been a sufficient restraint on trade in the market for the tied product (anesthesia services).

Having found that economic power over the tying product existed, the Fifth Circuit also held that the sharing of the profit by the hospital — particularly where the anesthesiologists had heavy use of nurse anesthetists — was anticompetitive.[7] Thus, the circuit court found that economic gain, not quality medical care, was the true purpose behind this contract.

Finally, the Fifth Circuit set forth the standard by which it would judge tying arrangements:

> An illegal tying arrangement will never be excused if there is a less restrictive way to accomplish the end which the business justification purports to serve.
> 686 F.2d at 292.



Based upon this standard, the court proceeded to criticize each alleged justification for the tying arrangement in question due to the existence of less restrictive alternatives. Thus, the court of appeals, applying a *per se* standard, found the exclusive contract illegal.

The Supreme Court unanimously reversed this decision of the Fifth Circuit, finding that, under the record before the Court, there was insufficient proof of an illegal tying arrangement. The Court split 5 to 4, however, on the applicable legal standard to apply. The majority reaffirmed the applicability, in certain cases, of *per se* illegality to tying arrangements. The Court noted that it was "far too late in the history of our antitrust jurisprudence to question the proposition that certain tying arrangements pose an unacceptable risk of stifling competition and therefore are unreasonable 'per se'."

The concurring opinion, written by Justice O'Connor and joined in by Justice Burger, Powell and Rehnquist, advocated a significant change in antitrust analysis by arguing that "the time has therefore come to abandon the 'per se' label" on tying arrangements. The concurring opinion urged a rule of reason analysis in tying cases, condemning such arrangements only where there is a "substantial threat that the tying seller will acquire market power in the tied-product market."

Several key points emerge from an analysis of the decision in *Hyde* which affect the manner in which hospitals and hospital-based physicians can structure their affairs. Unfortunately, the degree of "guidance" offered by the Court's opinion may be minimal at best.

Existence of a Tie. The fundamental requirement of a claim of tying is that there are two distinct products involved in the tying relationship. In any tying claim, therefore, plaintiff must demonstrate that independent products were involved in the arrangement in question.

In *Hyde*, both the district court and the court of appeals essentially presumed that two distinct products were involved — i.e., the tying product (operating rooms) and the tied product (anesthesia services).[8] This conclusion that separate products were involved finds support in the fact that the clinical practice of anesthesiology is independent of hospital support services to a significant degree. Anesthesiologists are called upon to diagnose, treat, and care for patients directly.[9] Indeed, the strongest support for the clear existence of two products is the fact that anesthesia services were provided to the hospital in *Hyde* by a completely distinct economic entity.[10]

In contrast, East Jefferson Hospital

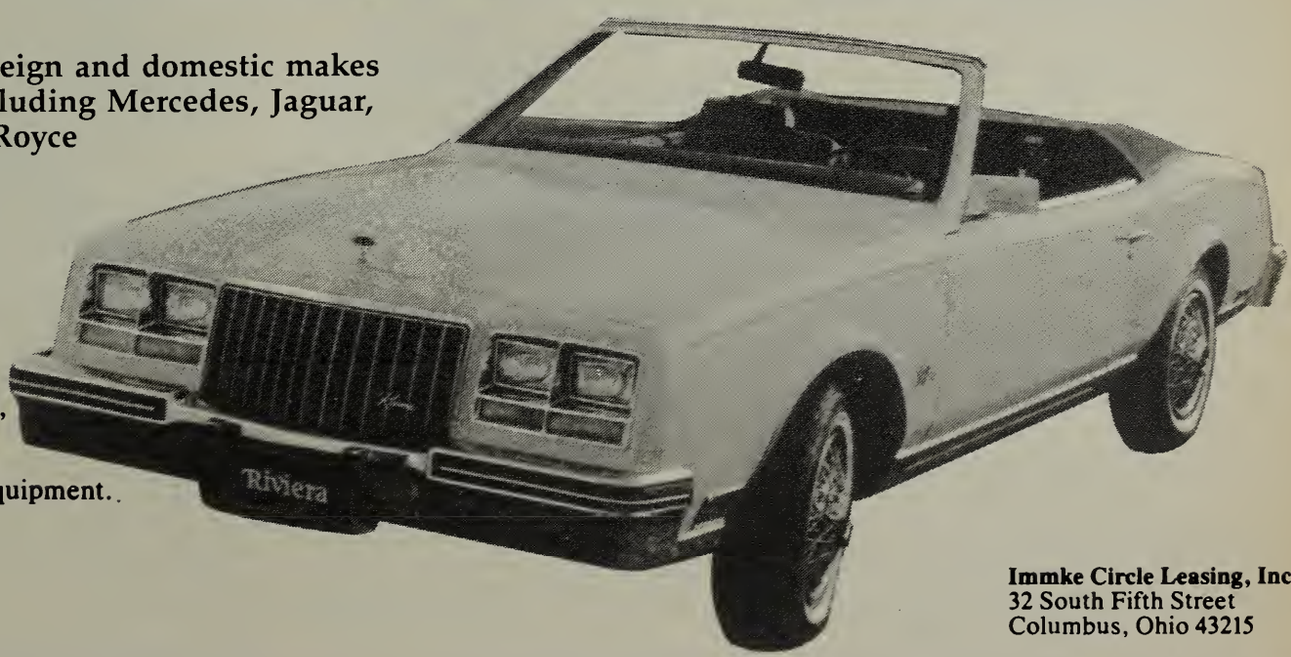
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argued on appeal to the Supreme Court that the hospital offered one service — operating rooms — and that the ancillary support (such as anesthesia) was incidental to this main purpose. The hospital argued that it had achieved "complete functional integration" and that the service or product offered to the public was a vertically integrated unit. In support for the hospital's position in *Hyde*, commentators, too, have endorsed the concept that the hospital and medical staff are joint producers of one product — "hospitalization services."[11] This unitary product approach, it is argued, is consistent with the teaching of *Professional Engineers, supra*, that courts in antitrust cases should be sensitive to the special facts of professional situations. Moreover, courts have refused to consider related items as two products where the buyer did not discriminate between the items,[12] or where economic efficiency and technical quality were significantly enhanced by one package.[13]

The Supreme Court upheld the finding of the lower courts that a tying arrangement existed under the record before the Court. The Supreme Court, however, found the issue of "functional integration" to be irrelevant:

> the answer to the question whether one or two products are involved turns not on the functional relation between them, but rather on the character of the demand for the two items.

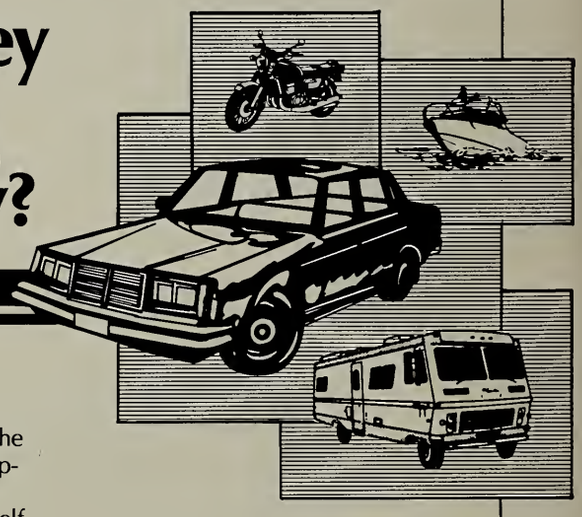
The Court, utilizing this framework, then found that there was sufficient demand for the purchase of anesthesiological services separate from hospital services to identify a distinct product market in a tied product.

While finding a tie under the exclusive anesthesiology contract in question, the Court, nevertheless, opened the door for uncertainty with other hospital-based physicians. In footnote 36, the Court noted that only 27% of anesthesiologists have a financial relationship with hospitals — thereby implying that anesthesiology was separate from hospital services. This fact led the Court to suggest that in "this respect anesthesiologists may differ from radiologists, pathologists, and other type of hospital-based physicians."[14] Thus, given an identical contract as in *Hyde*, with the exception that radiologists are the contracting physicians, the Court may find that no tie exists due to the fact that there is not an independent market for the tied services (radiology). Each specialty, therefore, may need to be analyzed separately in order to determine whether it offers a market separate and distinct from the hospital.

Another uncertainty in the Supreme Court opinion centers around the tying concept of two separate sellers. An essential element of the illegal tie in *Hyde*, according to the Fifth Circuit, was the economic benefit received by the hospital from the existence of the exclusive contract itself. The absence of this "profit factor" led several courts after the Fifth Circuit opinion in *Hyde* to conclude that no tie exists in an exclusive contract in which the hospital does not share in the anesthesia group's profit.[15] The basis for this distinction was that in the case of *Hyde* the entity offering the tying product had an economic interest in the tied product — i.e., the hospital received a profit from the anesthesia services themselves. Generally both products in the tying arrangement must be offered by the same seller. However, a tie may still be found to exist even if the sellers are separate, so long as the seller imposing the tie (in this case the hospital) has some economic interest in the supplier of the tied product or derives some benefit from the sale of the tied product.[16] Thus, if in fact anesthesia services and hospital care are two distinct products and yet there is no economic benefit

continued on page 479

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Obituaries

JAMES OLIN BEAVIS, MD, Boca Raton, Florida; University of Michigan Medical School, Ann Arbor, Michigan, 1929; age 87; died January 29, 1984; member OSMA and AMA.

NORMAN BLEY, MD, Cleveland; Ohio State University College of Medicine, 1963; age 45; died March 4, 1984; member OSMA.

R.H. BRENEMAN, MD, Akron; Ohio State University College of Medicine, 1936; age 73; died March 30, 1984; member OSMA.

RALPH CAROTHERS, MD, Cincinnati; University of Cincinnati College of Medicine, 1916; age 92; died March 28, 1984; member OSMA and AMA.

BENNETT P. COHEN, MD, Dayton; Ohio State University College of Medicine, 1944; age 66; died February 3, 1984; member OSMA and AMA.

WILLIAM W. CORWIN, MD, Willard; Case Western Reserve University School of Medicine, 1930; age 80; died March 8, 1984; member OSMA and AMA.

FREDERICK A. DOWDY, MD, Lancaster; Case Western Reserve University School of Medicine, 1939; age 71; died March 11, 1984; member OSMA and AMA.

I. HENRY EINSEL, MD, University Heights; Case Western Reserve University School of Medicine, 1923; age 87; died April 1, 1984; member OSMA and AMA.

HERBERT EMSWILER, MD, Delray Beach, Florida; Ohio State University College of Medicine, 1926; age 92; died September 23, 1983; member OSMA and AMA.

HARRY GAUCHAT, MD, Paris; Case Western Reserve University School of Medicine, 1918; age 90; died April 9, 1984; member OSMA and AMA.

RALPH HEERY, MD, Cincinnati; University of Cincinnati College of Medicine, 1941; age 69; died March 6, 1984; member OSMA and AMA.

JACK I. JAFFA, MD, Cleveland; Ohio State University College of Medicine, 1931; age 79; died March 18, 1984; member OSMA and AMA.

HARVEY KNOWLES, JR., MD, Cincinnati; Columbia University College of Physicians & Surgeons, New York, 1942; age 68; died March 17, 1984; member OSMA.

JOHN C. McDONALD, MD, Massillon; Case Western Reserve University School of Medicine, 1943; age 67; died April 12, 1984; member OSMA and AMA.

CHARLES McDOUGAL, MD, St. Petersburg, Florida; Case Western Reserve University School of Medicine, 1918; age 90; died February 20, 1984; member OSMA and AMA.

WILLIAM J. MILLER, MD, Columbus; Indiana University School of Medicine, Indianapolis, 1938; age 75; died April 11, 1984; member OSMA and AMA.

DARYL MULLHOLAND, MD, Lake Worth, Florida; Ohio State University College of Medicine, 1935; age 80; died March 5, 1984; member OSMA and AMA.

ALBERT T. RANSONE, MD, Palm Beach Shores, Florida; Medical College of Virginia, Richmond, Virginia, 1916; age 93; died February 2, 1984; member OSMA and AMA.

HENRY W. RYDER, MD, Cincinnati; University of Chicago Pritzker School of Medicine, Chicago, Illinois, 1937; age 70; died March 13, 1984; member OSMA.

WILBUR D. TURNER, MD, Marietta; Ohio State University College of Medicine, 1927; age 84; died April 3, 1984; member OSMA and AMA.

GEORGE T. WATROUS, MD, Cleveland; University of Cincinnati College of Medicine, 1983; age 29; died March 18, 1984; member OSMA and AMA.

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Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

* Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

Please see PROCARDIA *brief summary on adjoining page.*

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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The Physician and Ohio Law

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to the seller by the use of the designated supplier of the tied product, then a tying arrangement does not exist.

The Supreme Court did not even discuss this distinction in its opinion. Thus, in future cases, the existence or lack of economic benefit derived by the hospital in the tied product may be a key element allowing lower courts to distinguish the result in *Hyde*.

Economic Power over the Tying Product. Proof of sufficient economic power in the context of exclusive contracts with hospitals is indeed a potentially difficult burden for the plaintiff. As recently discussed by the Supreme Court, this element does not require a showing of domination by the seller of the tying product in the relevant market.[17] Rather, the Supreme Court has held that tie-ins are illegal if there is merely some "appreciable economic power" over the tying product, a standard which does not require "that the defendant have a monopoly or even a dominant position throughout the market for a tying product."[18]

Economic power, however, can only be measured with reference to a specific geographic market for the hospital's services. The definition of this geographic market will in large measure decide the issue of economic power.[19] The district court in *Hyde* held that the relevant geographic market included an area of at least 20 hospitals, and therefore concluded that if both patient and surgeon are free to go to any one of a large number of competent institutions, the hospital does not possess the power to force the tied product upon consumers. *Hyde v. Jefferson Parish Hospital District No. 2, supra,* 513 F. Supp. at 540. Other courts have accepted this reasoning. *See Santos v. Columbus-Cuneo-Cabrini Medical Center,* 684 F.2d 1346 (7th Cir. 1982); *Harron v. United Hospital Center, Inc.* [1975-2 TRADE CASES ¶60,474]. 522 F.2d 133 (4th Cir. 1975) *(per curiam), cert. denied,* 424 U.S. 916 (1976). However, the Fifth Circuit in *Hyde* took note of several market imperfections in the

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health care industry. "First, the prevalence of third party payment of bills eliminates a patient incentive to compare the relative cost effectiveness of competing hospitals. A second market imperfection is the lack of complete information regarding the quality of medical care offered. *Hyde v. Jefferson Parish Hospital District No. 2, supra,* 686 F.2d at 290. Therefore the Court concluded, patients tend to choose hospitals by location rather than price or quality, which means that the geographic market area apparently may subsume only an individual hospital.

The Supreme Court abandoned traditional formulas and labels for market power, however, and focused on the actual effects in the marketplace involved in the case before it. While this "hands-on" approach has some inherent appeal, the effect of this ruling will be to cast doubt on any definition of market power. The Fifth Circuit in *Hyde* had found market power due to market imperfections which made patients tend to choose a local hospital. The Supreme Court acknowledged these unique market factors in the hospital market yet failed to find that market power existed as it chose to define the term: "while these factors may generate 'market power' in some abstract sense [footnote omitted], they do not generate the kind of market power that justifies condemnation of tying." Market power only exists, the Court noted, when power over the tying product "forces patients to buy services they would not otherwise purchase." The Court found that the record before it "contains no evidence that the hospital 'forced' any such [anesthesia] services on unwilling patients." If patients truly cared about what anesthesiologists they had for surgery they could choose another hospital where that anesthesiologist was permitted to work.

Thus, despite recognized market factors that indicated market power in an "abstract sense" the Supreme Court found no "real" power over the tying product. Now a plaintiff in any tying case must demonstrate that the defendant "forced" the plaintiff to buy the tied product. This forcing, moreover, will not necessarily be presumed even if certain formal indicia of market power are present. The full ramifications of this characterization of market power are far from clear.

The final point, then, is a recognition that even on the basis of tying, after the Supreme Court decision in *Hyde*, challenges to exclusive contracts will certainly continue. The multitude of legal theories available to plaintiffs were untouched by the Court in *Hyde*. Moreover, the myriad factual differences between any case make it almost impossible for any court to satisfactorily answer the general question of the validity of exclusive contracts. Thus, as the market forces act to create greater demand for hospital privileges the excluded will be harder hit and will more frequently seek judicial resolution of the legality of the exclusion. **OSMA**

Footnotes

1. *See* Katz, Warner & Whittington, *The Supply of Physicians and Physicians' Incomes: Income Projections,* 2 J. HEALTH POL., POL'Y & L. 227 (1977); *U.S. Report Projects Oversupply of Doctors by 1990,* N.Y. Times, April 14, 1980, at A-16.
2. These policies include certificate-of-need controls over entry, *See The Certificate-of-Need Laws in Health Planning,* 1978 UTAH L.Rev. 1, and other federal and state laws that are designed to limit hospital revenues. *See generally* D.S. ABERNETHY & D.A. PEARSON, REGULATING HOSPITAL COSTS: THE DEVELOPMENT OF PUBLIC POLICY (1979); Lewin, Somers & Somers, *State Health Cost Regulation: Structure and Administration,* 6 U. TOL. L. REV. 647 (1975). Similarly, the TEFRA regulations concerning prospective payment and extensive reliance on DRGs point out the careful scrutiny which will be given hospital costs.
3. *Cardio-Medical Associates Ltd. v. Crozer-Chester Medical Center,* _____ F.2d _____ (3d Cir. 1983) (BNA Antitrust & Trade Reg. Rep. Nov. 24, 1983).
4. *Konik v. Champlain Valley Physicians.* 1983-1 Trade Cases ¶65,363 (N.D. N.Y. 1983); *Everhart v. Jane C. Stormont Hospital,* 1982-1 Trade Cases ¶64,703 (D. Kan. 1982); *Crane v. Intermountain Health Care,* 637 F.2d 715 (10th Cir. 1981); *Robinson v. Magovern,* 521 F. Supp. 842 (W.D. Pa. 1981); *But see, Furlong v. The Long Island College Hospital,* 710 F.2d 922 (2d Cir. 1983), and *Tarleton v. Mehary Medical College,* No. 82-5449 (6th Cir. 1983) (Slip Opinion Sept. 20, 1983).
5. This justification was the primary basis upon which most state court decisions in the past have uniformly justified exclusive contracts. *Centeno v. Roseville Community Hospital,* 167 Cal. Rptr. 183 (Cal. App. 1979); *Dattilo v. Tucson General Hospital,* 533 P.2d 700 (Ariz. 1975); *Blank v. Palo-Alto Stanford Hospital Center,* 234 Cal. App. 2d 377, 44 Cal. Rptr. 118 (Cal. 1965); *Letsch v. Northern San Diego County Hospital,* 246 Cal. App. 2d 673, 55 Cal. Rptr. 118 (Cal. 1966); *Douglas v. Hospital of St. Raphael,* 371 A.2d 396 (Conn. 1976) [State antitrust statute inapplicable to exclusive contract.]; *Moler v. White,* 336 So.2d 427 (Fla. Dist. Ct. App. 1976) [Practice of medicine not covered by state antitrust statute under trade or commerce absent clearly expressed legislative intent.]; *Rush v. City of St. Petersburg,* 205 So.2d 11 (Fla. 1967); *Rumple v. Bloomington Hospital,* 422 N.E.2d 1309 (Ind. App. 1981); *Sokol v. University Hospital, Inc.,* 402 F. Supp. 1029 (D.C. Mass. 1975); *Wolf v. Jane Phillips Episcopal-Memorial Center,* 513 F.2d 684 (10th Cir. 1975); *Harron v. United Hospital Center,* 522 F.2d 1133 (4th Cir. 1975), *cert. denied,* 96 S.Ct. 1116 (1976); *Benell v. City of Virginia,* 104 N.W.2d 633 (Minn. 1960); *Adler v. Montefiore Hospital Association of Western Pennsylvania,* 311 A.2d 634 (Pa. 1973).
6. 686 F.2d at _____. This statement is somewhat curious in light of the fact that the briefs in support of the hospital in the Supreme Court argue strenuously that no tie existed. So, too, the failure of proof as to an actual tying arrangement was argued before the Supreme Court in early November, 1983 during the oral arguments in *Hyde.*
7. The Fifth Circuit found the primary purpose of the tie was economic gain. Thus, the Fifth Circuit discounted the quality of care rationales put forth in the case. The court found patients

lacked free choice as to anesthesia services and that anesthesiologists were unfairly excluded from the hospital staff.

8. *See* 686 F.2d 286, 289 (5th Cir. 1982) ("The existence of a tying arrangement in this case has never been seriously disputed by appellees, since it is clear that . . . we are dealing with two distinct services which a buyer should be able to obtain separately"). *See also* 513 F. Supp. 532, 540 (E.D. La. 1981).
9. Indeed, the American Society of Anesthesiologists argues in its *amicus* brief before the Supreme Court in *Hyde* that anesthesiologists are fundamentally different from other "hospital based" physicians such as pathologists and radiologists. The latter groups do not practice in a direct physician-patient relationship; moreover, both pathologists and radiologists do not need to be in the hospital itself to perform their services.

   Interestingly, it may be possible to have a tying arrangement between anesthesiologists but no tie with pathologists or radiologists, even with identical contracts.
10. *See*, e.g., *Fortner Enterprises, Inc. v. United States Steel Corp.* ("Fortner I"), 394 U.S. 495 (1969), where credit and the sale of the product were viewed as different products.
11. Kissam, Webber, Bigus & Holzgraefe, "Antitrust and Hospital Privileges: Testing the Conventional Wisdom," 70 Calif. L. Rev. 595, 666 (1982) (hereinafter "Kissam"); Pauly and Redisch, "The Not-for-Profit Hospital as a Physicians' Cooperative," 63 Am. Econ. Rev. 87, 88 (1973).
12. *Times-Picayune Publishing Co. v. United States*, 345 U.S. 594, 613-614 (1953).
13. *See Siegel v. Chicken Delight*, 448 F.2d 43, 48 (9th Cir. 1971), *cert. denied*, 405 U.S. 955 (1972); *Dehydrating Process Co. v. A.O. Smith Corp.*, 292 F.2d 653, 655 (1st Cir. 1961); *Automatic Radio Mfg. Co. v. Ford Motor Co.*, 242 F. Supp. 852, 855-58 (D. Mass. 1965); *United States v. Jerrold Elecs. Corp.*, 187 F. Supp. 545, 559-60 (E.D. Pa. 1960), *affirmed per curiam*, 365 U.S. 567 (1961). *See generally*, Ross, *The Single Product Issue in Antitrust Tying: A Functional Approach*, 23 Emory L.J. 963 (1974).
14. This distinction finds support in the fact that anesthesiologists (as opposed to other hospital-based specialists) have direct patient contact and frequently bill separately. See footnote 9, *supra*.
15. *Griffing v. Crosby Memorial Hospital*, 1984-1 Trade Cases ¶65,854 (S.D. Miss. 1984); *Panaro v. Palm Beach — Martin County Medical Center*, No. 82-539 CA (L) 01 G, 7/11/83, Palm Beach Circuit Court.
16. *Keener v. Sizzler Family Steak Houses*, 597 F.2d 453 (5th Cir. 1979); *Ohio-Sealy Mattress Mfg. Co. v. Sealy, Inc.*, 585 F.2d 281 (7th Cir. 1978); *Kentucky Fried Chicken Corp. v. Diversified Packaging Corp.*, 549 F.2d 368 (5th Cir. 1977); *Arthur Murray, Inc. v. Reserve Plan, Inc.*, 406 F.2d 1138 (8th Cir. 1969); *Osborn v. Sinclair Refining Co., supra; United States v. General Motors Corp.*, 121 F.2d 376 (7th Cir. 1941).
17. *But see* subsequent modification of this requirement by the Supreme Court in *Hyde*.
18. *United States Steel Corp. v. Fortner Enterprises, Inc.*, 429 U.S. 610, 611-620 (1977).
19. The geographic market is the area in which the seller competes and where the buyer would look for a supply of the goods or services.
20. Kissam, *supra*, n. 11.

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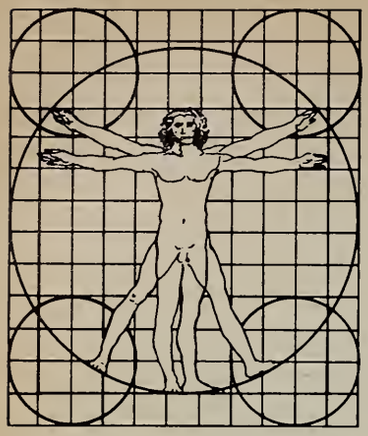
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CLINICAL & SCIENTIFIC

TWENTY-FIVE YEARS EXPERIENCE WITH CARDIOPULMONARY RESUSCITATION

William Hamelberg, MD

The author presents his experience with the evolution of cardiopulmonary resuscitation. This experience occurred in a large University Hospital and a 400-bed community hospital. During this time period, the training of personnel, drugs and equipment have markedly improved. These changes resulted in successful resuscitation efforts from 38% in 1957 to 47% in 1982.

THE AUTHOR PARTICIPATED in two reviews of the resuscitation experience in a large University Hospital.[1,2] In the time interval, the techniques and equipment for resuscitation, now called cardiopulmonary resuscitation (CPR), have become more sophisticated, with CPR performed by medical personnel with various training levels and experience. This report presents the CPR experiences in a 400-bed adult community general hospital.

Results

Saint Anthony Hospital is an adult patient, 400-bed community general hospital. The Nursing Service Policy utilizes the hospital paging system to alert the hospital staff for personnel assistance in a cardiopulmonary resuscitation effort. The responding team consists of a physician, respiratory technician, pharmacist and other available medical personnel. A special form (Table I) is completed on each effort and is completed by a nurse during the CPR effort. The forms for each month are reviewed by the Special Care Committee with an analysis done of the procedures used, drugs and the end result. The data for this report was obtained for the year 1982, and placed in a personal computer for analysis. A CPR effort was considered successful if the patient returned to his pre-resuscitation status. A summary of the results for the studies completed for the years 1957 and 1964 are included for comparison.

TABLE I

Date & Time of Code
Diagnosis (Primary)
Precipitating Symptoms
Personnel Responding & Arrival Time
Medications
Airway Management
Circulation Management

William Hamelberg, MD, is Professor Emeritus (Anesthesiology)
Ohio State University
Director of Critical Care, Saint Anthony Hospital
Submitted June 6, 1983

For the year, there were 133 CPR efforts on 122 patients, with six patients having more than one CPR effort. The sex distribution is shown in Table II, with an overall success rate of 47%, compared to 38% in 1957 and 25% in 1964. As expected, the age distribution reflected the general hospital population, with 111 patients above the age of 50 (Table III).

Most of the patients had multiple system disease processes. Table IV shows the primary diagnosis for which the patient was admitted with cardiovascular (CVD), central nervous system (CNS), and respiratory system diseases representing the majority of the primary diagnoses.

TABLE II
SEX

	SUCCESSFUL	EXPIRED	TOTAL
FEMALE	24 (42%)	33 (58%)	57
MALE	33 (51%)	32 (49%)	65
TOTAL	57 (47%)	65 (53%)	122
1957	38 (38%)	62 (62%)	100
1964	69 (25%)	210 (75%)	279

TABLE III

AGE	SUCCESSFUL		EXPIRED		TOTAL	
11-20			1		1	
21-30	1		2	(9%)	3	(9%)
31-40	2	(9%)	3		5	
41-50	2				2	
51-60	14		7		21	
61-70	16		13		29	
71-80	16	(91%)	28	(91%)	44	(91%)
81-90	5		8		13	
91-100	1		3		4	
TOTAL	57	(47%)	65	(53%)	122	

Table IV gives, in 20 minute intervals, the time spent in the CPR effort, with 104 efforts completed within 40 minutes. As a result of the CPR efforts, 13 patients were discharged home or considered recovered enough to be discharged from the ICU back to routine floor care.

TABLE IV
PRIMARY DIAGNOSIS

	SUCCESSFUL	EXPIRED	TOTAL	1957	1964
CNS	6	7	13	54	61
Drugs	1		1	17	21
CVD	22	22	44	11	88
Metabolic	2	9	12	7	16
Resp.	10	10	20	5	13
Sepsis	8	6	14		4
Cancer		5	5	1	19
Trauma	5	1	6		
Vascular & Bleeding	2	5	7	2	15
TOTAL	56	65	122	97	237

Discussion

In the time period from the report in 1957 to this report, marked advances have occurred in CPR. The 1957 report dealt only with problems associated with airway obstruction and/or inadequate respiratory exchange. These problems were handled by highly skilled individuals, usually using endotracheal intubation. External cardiac massage and cardiac defibrillation were not available. It is, therefore, not surprising that only 38% of the patients survived.

The 1964 report reflects the introduction of external cardiac massage and cardiac defibrillation. The low survival rate (25%) reflects the fact that, during this time, external cardiac massage and cardiac defibrillation were in the early stages of development, patients had a CPR effort in the terminal phase of their disease and prior to the development of newer, more sophisticated monitors and cardiovascular drugs.

This 1982 report reflects the marked improvement in monitoring and defibrillation equipment, elimination of patients in the terminal phase of their disease, a vast array of available cardiovascular drugs and better training of all medical personnel in CPR. The Joint Commission on Accreditation of hospitals, as part of its accreditation process, requires evidence that personnel involved in patient care have continuing education in CPR and that this be documented in the individuals' personal files. In addition, the importance of CPR in saving lives is reflected in the national effort to train the lay public in the basic principles of CPR. The success of these programs is reflected in newspaper reports of successful resuscitation of drowning victims and individuals sustaining a myocardial infarction.

TABLE V
TIME OF CPR EFFORT

MINUTES	PATIENTS
0-20	63 (47%)
21-40	41 (31%)
41-60	17 (13%)
over 61	12 (9%)
TOTAL	133

The success rate of CPR in this report (47%) is a reflection of better trained personnel, early recognition of signs of falling ventilation and circulation, the wide use of monitoring equipment and marked improvement in cardiovascular drugs.

In 1957, 17% of the CPR efforts were for drug overdose, compared to less than 1% in this report, a reflection of better training of emergency personnel resulting in early endotracheal intubation to support ventilation without calling for the CPR team.

Overall central nervous system, cardiovascular disease and respiratory system diseases, in all three reports, as expected, comprised the majority of the primary disease diagnoses in patients receiving a CPR effort.

Not available in the first two reports was the time spent in the CPR effort; however, in this report, 78% of the CPR efforts lasted less than 40 minutes (Table V). Most of the successful CPR efforts were during this time; however, one patient who was discharged from the hospital had a successful CPR effort that lasted two hours.

Unanswered by this report is the question of who should have a CPR effort. The author has noticed during the time involved in all three reports, that there have been more medical decisions made not to perform CPR. The medical profession still lacks the definitive ability to diagnose patients who will benefit from CPR efforts and return to a useful life.

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1. Ziegler CH, Jacoby J: Emergency Service Within The Hospital. JAMA, Vol. 164: 1432-1434, 1957.
2. Jordan D, Lavin T, Hamelberg W: Resuscitation Experience Within the Hospital. JAMA, Vol. 188: 181-182, 1964.

Next month in:

THE Ohio STATE Medical Journal



The Annual Meeting Wrapup

Highlights of the 1984 OSMA Annual Meeting will be featured in this issue, including pictures of the installation of the new OSMA President, A. Burton Payne, MD.

CLINICAL NOTES

Edited by Karen S. Edwards

Brain-Stem Damage in 'SIDS' Described

The first description of focal brain-stem damage in sudden infant death syndrome is noted by James B. Atkinson, MD, PhD, of Vanderbilt University, and colleagues. They describe the sudden death of an 8-month-old infant with damage to the "dorsal nucleus of the vagus nerve," apparently caused by ischemia (deficiency of blood supply). The nerve cells that initiate and maintain respiration are located in the dorsal motor nucleus of the vagus nerve, they point out, and say "Damage to these neurons could result in apnea (cessation of breathing) and subsequent death."

— *Archives of Pathology and Laboratory Medicine*

Hyperthermia in Cancer Therapy

Inducing whole-body hyperthermia (increased body temperature) is a promising adjunct to radiation or chemotherapy for solid tumors but is still clearly investigational, according to the AMA's Diagnostic and Therapeutic Technology Assessment (DATTA) panel. In a DATTA report, the panel notes some drawbacks associated with hyperthermia therapy: the need for general anesthesia; rapid heartbeat and other reactions seen in induced fevers; posttreatment burns, nausea, vomiting and respiratory distress; and the inability to precisely control tissue temperature. The optimal frequency and duration of hyperthermia treatments may vary with the nature of the target tumor, the DATTA panel suggests.

— *Journal of the American Medical Association*
January 13, 1984

Reye's Syndrome and Aspirin Therapy

The low incidence of Reye's syndrome among children receiving long-term aspirin therapy for inflammatory disorders has been cited as evidence against a causal relationship between the drug and the disease. Two such cases demonstrate findings of impaired liver function that is both a hallmark of Reye's syndrome and a well-recognized toxic effect of long-term aspirin therapy in children. Similarities and differences between this aspirin hepatotoxicity and Reye's syndrome raise as yet unanswerable questions of whether they are part of the same clinical spectrum or distinct entities, writes Richard S.K. Young, MD, from Milton S. Hershey Medical Center, Hershey, Pa. Until aspirin is proven to have a causal or contributory role in Reye's syndrome, it should not be abandoned as an effective long-range therapy for juvenile rheumatoid arthritis, Young says.

—JAMA
February 10, 1984

Overdose Signals Serious Follow-Up

Life-threatening drug overdose often indicates serious psychiatric illness and increased risk of repeated overdose, according to Theodore A. Stern, MD, and colleagues. Their prospective study of 88 patients, admitted to the intensive care unit at Massachusetts General Hospital, shows that 8% had died (5% by overdose) and 42% had been readmitted for another nonfatal overdose or for psychiatric illness by the end of the average 10-months follow-up period. The authors noted that "the incidence of drug overdose is increasing, as is the need for medical attention for those who experience life-threatening overdose."

— *Journal of the American Medical Association*

Injectable Collagen for Skin Defects

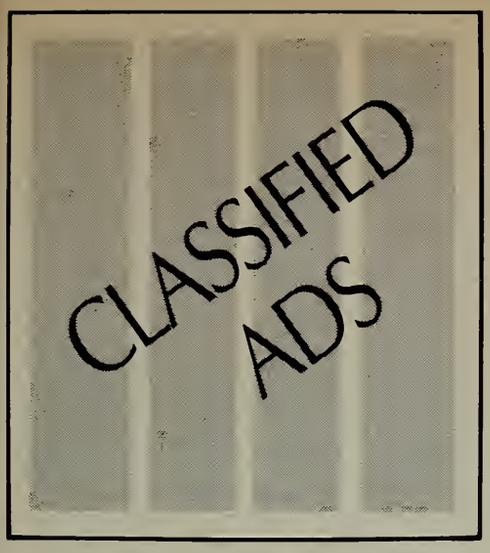
Injectable collagen is an easy to use, safe and effective method for minimizing some facial wrinkles and scars, say Frank M. Kamer, MD, and Michael M. Churukian, MD, from the UCLA School of Medicine and the University of Southern California School of Medicine, Los Angeles. Their review of results in 300 patients related facial lines, such as vertical "frown," furrows above the nose, and creases around the mouth, responded well. Results with acne scars were variable. Delayed hypersensitivity, their "only truly discouraging" complication, developed in 1.3% of the patients, with such reactions as persistent redness, swelling and itching.

Archives of Otolaryngology
February, 1984

Encephalitis Cases Decrease in Great Lakes

Only about half the expected number of encephalitis cases due to California serogroup viruses — the most prevalent type in this area — occurred in the Great Lakes states during 1983, according to a report which appeared in a recent issue of the *Journal of the American Medical Association (JAMA)*.

In spite of the unusually warm year, findings of the Ohio Vector-Borne Disease Unit indicate recovery of *Aedes triseriatus* larvae from ovitrap sites during 1983 was similar to rates for the previous year.



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Colleagues In The News

Edited by Ginny Strawser

JOSEPH C. AVELLON, MD, Director of Surgery and FRED R. PLECHA, MD, Chief of Peripheral Vascular Surgery from Lutheran Medical Center in Cleveland, are among the first surgeons in this country to be awarded the "Certification of Special Qualifications in General Vascular Surgery" by the American Board of Surgery. Both men passed the first vascular surgery certification examination in November, 1983.

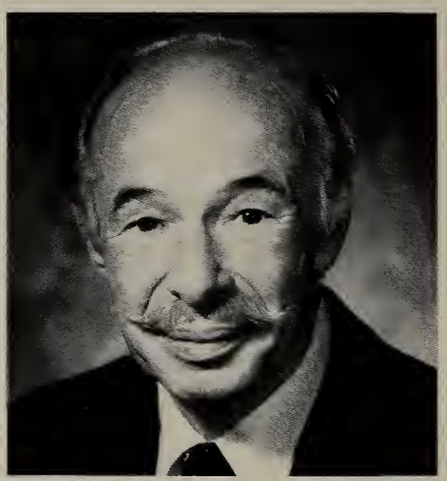
New officers have been elected at Providence Hospital in Cincinnati: LARRY BEST, MD, president; JOHN KRIEG, MD, vice-president; and JOHN ZERHUSEN, MD, secretary-treasurer.

Darke County Medical Society has elected its new officers for 1984: CHARLES E. REIER, MD, president; DANIEL S. BERGER, MD,. vice-president; and STEPHEN C. BREWER, MD, secretary-treasurer.

GEORGE P. LEICHT, MD, Cleveland, was re-elected Board President of the Cleveland Health Education Museum. Dr. Leicht will serve as chief executive officer of the Museum and chairman of the executive committee of the Board of Trustees.

JOHN R. SPER, MD, Cincinnati, has been elected President of the medical and dental staff at Cincinnati Children's Hospital Medical Center for 1984.

DAVID ROLF, MD, Euclid, was named Emeritus Director of Ophthalmology at Euclid General Hospital.



Mel A. Davis, MD

Saint Anthony Hospital in Columbus recently dedicated its newly remodeled laboratory in honor of MEL A. DAVIS, MD. Dr. Davis has been with Saint Anthony Hospital since 1949 and has served as Medical Director of the lab since 1964.

JOHN V. WEIGAND, MD, Akron, has been named 'Fireman of the Year 1983' by the Bath Fire Department for his dedication to the field of emergency medicine.

FRANK J. WEINSTOCK, MD, Canton, was re-elected President of the Society of Geriatric Ophthalmology.

FREDERICK J. WIECHER, MD, Mansfield, recently received a plaque commending him for his leadership as medical staff president during 1983 at Mansfield General Hospital.


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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted): Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215. Phone: 614/228-6971.

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

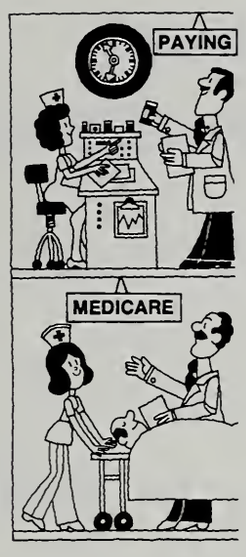
1983 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

THE Ohio STATE Medical Journal
(ISSN 0030-1124)



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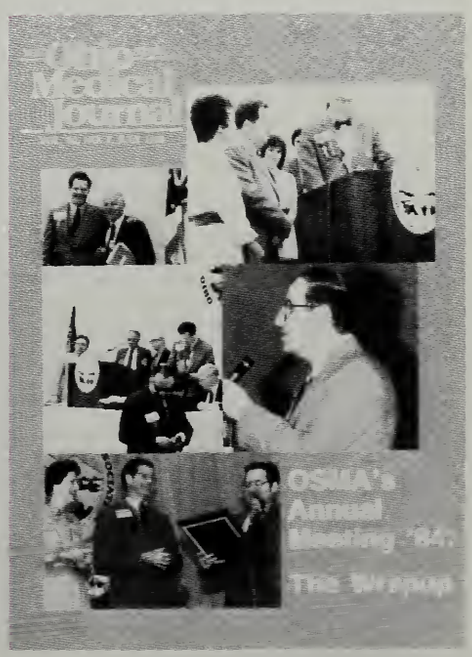
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Our Cover

Clockwise, starting at top right: C. Douglass Ford, MD, Toledo, OSMA Past President, installs A. Burton Payne, MD, Ironton, as OSMA's new President, as members of his family look on. Herman I. Abromowitz, MD, Dayton, OSMA's new President-Elect. Immediate Past President S. Baird Pfahl, Jr., MD, Sandusky, his wife, Phyllis (OSMA's Auxiliary's new president), and Dr. Payne. Members of the House's head table (l. to r.), Dr. Payne; James Pohlman, OSMA Legal counsel; Goodwin Berquist, parliamentarian; Dr. Pfahl; Hart Page, OSMA Executive Director. Oscar Clarke, MD, Gallipolis, is pictured in the foreground. Dr. Pfahl and Mr. Page.

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The Annual Meeting

Keeping Track of Medicine's Changing Face

There is probably no better indicator of what is going on in medicine today than the Ohio State Medical Association's (OSMA) Annual Meeting.

Although this year's theme was "DRGs: The Changing Face of Medicine," the prospective payment system (ushered into the Medicare program last October by the Federal government) was actually only *one* aspect of the changing face of medicine reflected during this year's meeting.

This issue of the *Journal* — the "Annual Meeting Wrapup" issue — explores the *other* concerns that were also voiced — some in the House by officers and delegates; others raised outside the House by thoughtful individuals both inside and outside the profession.

There is much more to this issue than an account of actions and events. Look beyond the prose to the swift undercurrent of issues and ideas that ebb and flow beneath its surface — like the current political events that subtly shape your practice. For example, in the Minutes of the House (which will run next month), look for the subjects being discussed, and how the House elected to act. You'll receive a pretty good picture of what is of concern to Ohio physicians, and why.

Look to the report on the OMPAC Luncheon. There, you'll see how and why the presidential election is shaping up the way it is.

Look at the story on the OSMA's new councilors, and you'll put your finger on the pulse of what today's medical leaders are all about. (The fact that one of the new councilors is a woman — the first female to ever sit on the OSMA Council, gives you an indication of the direction women in medicine are moving).

Look at the story on the clinical session. The internists are in their second year of holding symposiums on socioeconomic topics, and this year, they focused their attention on the pressures toward a two-tiered medical system. The issue is not one belonging to the internists, alone. It's an across-the-board concern that needs to be addressed by all health professionals. So look at the report and see how and why these pressures are occurring — and how they may (or may not) be affecting you.

The more you look at the Annual Meeting issue, the more you'll see. The reports of events and actions and "color" are all there — but look deeper — past the prose and pages of gray type. Hidden underneath is a wealth of information about Ohio medicine — as timely, vital and alive as the Annual Meeting itself. — *Karen S. Edwards.*

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J-4044 January 1984

Letters to the Editor

Cries of the Wounded

TO THE EDITOR:

Regarding the "Second Opinion" Column that ran in the May *Journal* ("For Whose Benefit?", William B. Saxbe, Jr., MD, *OSMA Journal*, May, 1984). Dr. Saxbe's points are well taken, but I can hear the cries of the wounded already: "How dare you say our fees are too high! After all, what value can one place on a human life?"

The answer, of course, is that one cannot set such a value — but one can set a reasonable fee! I suspect the high fees of cardiac surgeons and others are really just a method of auto-ego boosting. "Look how great I am. I can get this much for an operation."

Sincerely,
Brooks A. Mick, MD
Findlay, Ohio

Cancer Family Care

TO THE EDITOR:

The article "Handling Cancer's Emotional Side," in the May 1984 issue provides excellent coverage of that subject and addresses all the many issues involved.

Here at the Cincinnati based agency, Cancer Family Care, Inc., our trained social workers see these issues and help families to cope with them at every stage of the illness. We work with individuals, with families and with groups providing the emotional wherewithal to help patients and their families draw on their own strengths so that they can cope with the many changes in their lives.

Your words of advice sum up much of what is needed for the patients, and your additional suggestion of "Don't forget the family" is especially relevant.

As we see how quickly the patient and family can respond to these approaches, our only wish is that there were a Cancer Family Care to work in tandem with the medical profession in every locale of this country. Thanks to Drs. Hodge and Babai for a thoughtful and complete summary of the many non-medical issues which attend upon a diagnosis of cancer.

Sincerely,
Sue W. Ransohoff, A.C.S.W.
Casework Supervisor
Cancer Family Care, Inc.
Cincinnati, Ohio

Cancer . . . The Story Continues

TO THE EDITOR:

I enjoyed reading the article in the May 1984 issue of *The Ohio State Medical Journal* and reviewing the points that were made concerning advances in cancer management in the State of Ohio. There are two areas that I think probably need major emphasis. One is the role of the American College of Surgeons in its cancer approval program and what it requires of a hospital for approval of a cancer program. This was only briefly mentioned in one and a half lines on page 345 and may be the single most important aspect of the improvement of cancer management in the state. The description of the program and its impact on the health care management in the communities and individual hospitals should have been a major area of discussion. It is also important to note that the problem of not having a cancer registry would be solved because it is a requirement of the program that each hospital have a cancer registry to be approved.

The other thing that I thought was missing was the cancer research that has been started at The Ohio State University. Dr. Zollinger's work with the Zollinger-Ellison tumor is truly a pioneering experience with tumors of the pancreas. It actually started an avalanche of investigation of pancreatic and gastrointestinal tumors back in 1955. Subsequent to that, my work in Laser research in 1963, 1964, and 1965 has now given birth to an international explosion of surgical techniques using the Laser. In addition to that, research that started in 1971 and 1972 on CEA directed second look operations on colon cancer patients led to a way to cure as many as a third of the patients with recurrent colon cancer.

These were all started here by Ohio State University faculty members and are truly major contributions to the science and understanding of cancer in the State of Ohio and the world. I hope you will consider these points in future articles about cancer research.

Sincerely,
John Peter Minton, MD, PhD
Professor of Surgery
American Cancer Society Professor of Clinical Oncology

The OSMA Journal *welcomes letters from its readers. Please address all letters to: Executive Editor, 600 S. High St., Columbus, Ohio 43215. Letters may be edited to meet space requirements.*

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A Mental Health System — The Bureaucratic Approach

by Richard G. Sutton, MD

Instead of a Department of Health encompassing public health, mental health, mental retardation, etc., we have a separate Department of Mental Health, a separate Department of Mental Retardation and a separate Department of Health. Why not add a Department of Obstetrics and Gynecology . . .?

If one were to conceptualize a plan to destroy a health care delivery system, or at least, render it ineffective so as to conform to other federal and state agencies, how would he or she proceed?

The first step is to organize a departmental structure that makes no logical sense — in an effort to segregate an agency that has little "constituent" power. Instead of a Department of Health encompassing public health, mental health, mental retardation, etc., we have a separate Department of Mental Health and a separate Department of Mental Retardation and a separate Department of Health. Why not add a Department of Obstetrics and Gynecology, a Department of Thoracic Surgery or a Department of Pediatric Oncology? Are these medical specialties any less deserving of recognition or the status of a cabinet level post?

The second step, in my opinion, is to make a political appointment of agency leaders with no training, qualifications, experience or expertise in health care.

Then, one needs to extrude from positions of influence the most highly trained experts in the field and replace them with politically appointed folk who increase the amount of paperwork in an effort to further strangle a struggling system. One needs to devise a complex set of paradoxical, incomprehensive and conflicting rules to confuse and mystify the "providers." This creates the need for further "monitoring" and the expense of additional non-productive personnel.

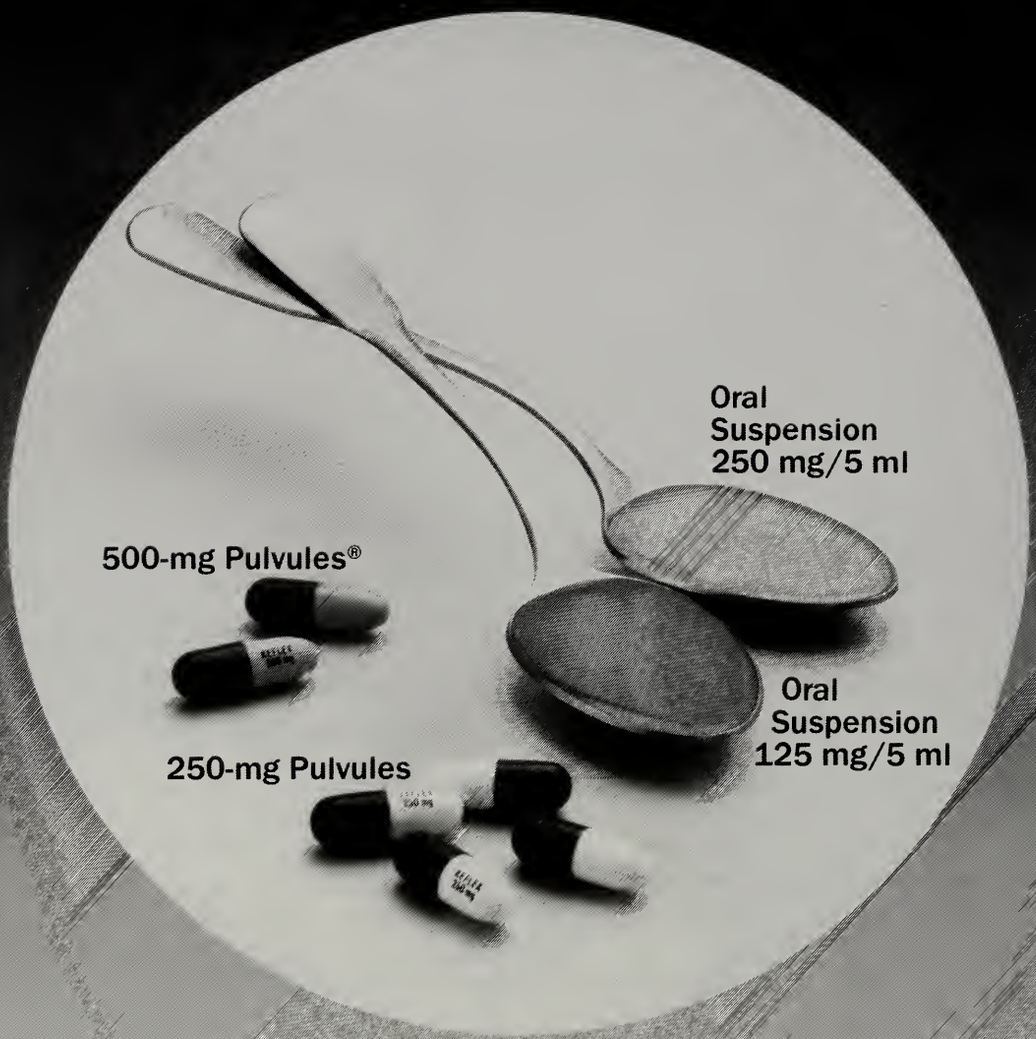
Next, the State needs to redefine the population for whom it is legislatively obligated to provide care. Previously hospitalized, mentally ill people become redefined as "street people" or the "homeless" and provide an excuse for establishing commissions, task forces, and studies resulting in financial squander to "access the problem." The prison population vascillates between designated "mentally ill" and "criminal." In one western state a much heralded deinstitutionalization program ultimately succeeded in filling the state's nursing homes.

Accomplishing the above, the state should gain input, in the form of "public forums" to see what the public wants and appear to be interested. The result of this is to effectively put medical care to referendum. Let's take a vote! Should we use psychotropic medicine or not? How about ECT? Incidentally, in one jurisdiction ECT was "voted down," but fortunately, the ruling was later set aside. What's next? A ban by public acclamation of appendectomies or penicillin?

The final steps of the plan are as

continued on page 499

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Second Opinion

continued

follows: Devote increasing resources to the third party organizations and the administrative function at the expense of the clinical services. Then, as a final touch, cut the budget, and blame the clinicians for running up too high a health care bill. **OSMA**

Richard G. Sutton, MD, practices psychiatry in Cincinnati, Ohio.

"Second Opinion" is a column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy. The JOURNAL encourages individual members to submit articles for this column. Preference will be given to short, concise articles which discuss the current issues of the day.

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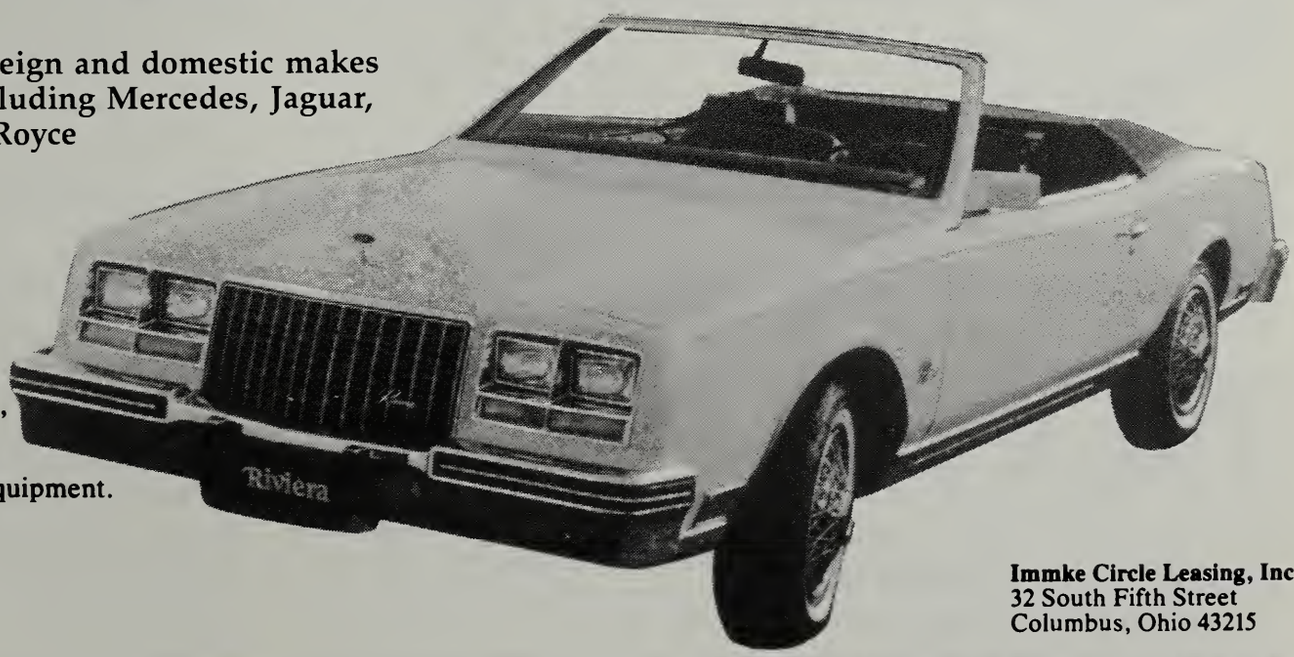
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Hart Page To Retire as Director of OSMA



Hart F. Page

Ohio State Medical Association Executive Director Hart F. Page, CAE, has announced he will retire December 31, 1985, after 40 years of service to the OSMA. The Dennison, Ohio native will leave the OSMA to pursue work as a private management consultant, as well as graduate studies in history at the Ohio State University.

Page, who received his BS in journalism from OSU in 1938, joined the OSMA in January of 1946 as assistant director of public relations and news editor of the *OSMA Journal*. He was named to his present position as executive director in January of 1965.

Under his leadership, Page saw the OSMA grow to a membership of over 17,000 physicians, residents and medical students. In addition, several subsidiary companies were formed during his tenure, including Physicians Insurance Company of Ohio, which is the largest wholly-owned professional liability company in the country, and Physicians Administrative Corporation of Ohio, which offers marketing and practice management services to OSMA members.

Page has also served as president of several local, state and national organizations. He is former vice-president of the American Society of Association Executives (ASAE), he served as chairman of ASAE's Evaluation Committee and for three years was chairman of its Effective Government Group, a predecessor of ASAE's A-PAC.

He also has served in numerous offices as a long-time member of the American Association of Medical Society Executives, including president of that organization for the 1979-1980 year.

A five-member transition team, headed by OSMA past-president S. Baird Pfahl, Jr., MD, has been established to bring the OSMA Council recommendations for an orderly transition process.

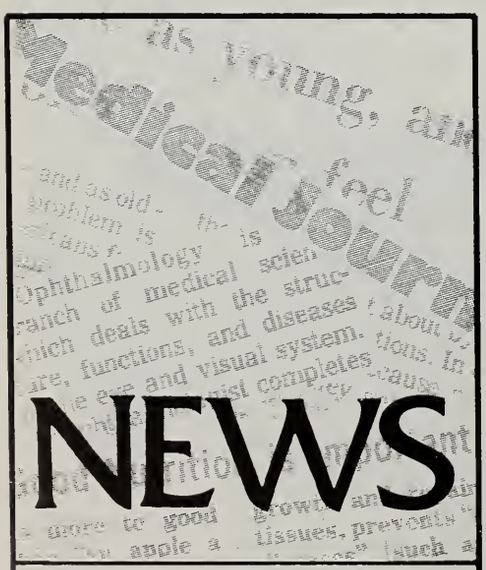
At the recent OSMA annual meeting in Cincinnati, Dr. Pfahl announced that a new building addition to OSMA office headquarters in Columbus will be named in honor of Page.

Changes in OSMA Staff

Catherine C. Costello, JD, assistant staff legal counsel for the OSMA, recently was named director of state legislation for OSMA. She is replacing Eric L. Burkland who has resigned to take a position as Director of Public Affairs with Ohio Medical Indemnity Mutual, Inc. (Blue Shield).

In addition, Michael L. Bateson, Assistant Director of State Legislation, recently resigned to become Executive Director of the Ohio Ophthalmological Association.

In other staff news, Doug Evans, former director of communications for the Central Ohio Arthritis Foundation, has been named editor of *Synergy* and a staff writer for the *Journal* under the OSMA Department of Communications.



a compilation of the latest developments, reports and products of interest to physicians.

edited by Susan Porter

Students Choose To Stay in Ohio

Thanks, in part, to a computer in Evanston, Illinois, medical students at the Northeastern Ohio Universities College of Medicine (NEOUCOM) will be staying in their home state at least a few more years.

The computer, which is used by the National Resident Matching Program, matches graduating medical students with hospitals accepting first-year interns and residents. It enables students to select first, second and third choices for their three to six year residency training programs in family medicine, internal medicine, surgery, etc.

In the most recent match involving 1984 May graduates, two-thirds of the students received first choice while 85% got one of their first three choices, according to the April, 1984 *NEOUCOM* newsletter. Of the 74 students who will graduate from NEOUCOM in May, 73% have accepted residency placement in Ohio, with 61% staying in northeast Ohio and 50% in the NEOUCOM consortium hospitals in Akron, Canton and Youngstown. Some 58% of the students opted for primary care residencies.

"For the fourth year, the placement of NEOUCOM students is consistent with the goals of the college to place students in Ohio, particularly northeast Ohio," James R. Boex, associate dean for student affairs, says in the *NEOUCOM* publication.

PRO Continues To Suffer Setbacks

Operation of a new Medicare review system has suffered yet another delay in 15 states where all the bids for the peer review organization (PRO) contracts have been rejected as "technically unacceptable."

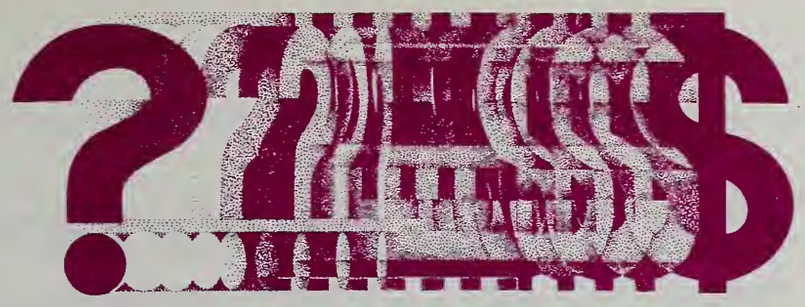
The rejected states have about 40% of all Medicare hospitalizations. New bidders there, along with the 18 rejected organizations, had until the first of this month to submit proposals. The rejected organizations met with Health Care Financing Administration (HCFA) officials to learn the specific deficiencies in their bids.

In two states — California and Michigan — multiple bids were submitted and rejected, according to HCFA spokesmen. In the other 13 states, only one bid was submitted. They are: Alaska, Connecticut, Hawaii, Idaho, Illinois, Maine, Ohio, Oklahoma, Pennsylvania, Texas, Vermont, Virginia and Washington.

In issuing the notice of reopened bids, HCFA noted that if it finds "no proposal acceptable" in the 15 areas, it will be "required to award a contract to a payer organization for that area."

Officials in charge of implementing PROs added, however, that they "still feel very strongly that PROs should be run by physician-sponsored organizations," and are "giving the physician community every opportunity to participate."

The Ohio State Medical Association's House of Delegates recently rejected a proposal that the OSMA become the PRO for Ohio. For their reasons, see the June issue of the *Ohio State Medical Journal.*



Price Wars May Result From PPOs

Taking a business approach to health care can have its advantages and disadvantages, write the authors of a new book soon to be published by Dow Jones-Irwin Publishing Company.

Titled *Preferred Provider Organizations* (PPOs), the book takes a look at this relatively new phenomenon wherein groups of health care providers offer discounted or negotiated rates to employers and consumers.

While effective management techniques may result in cost-savings for both providers and consumers involved in PPOs, other strategies — such as price discounting schemes designed simply to lure purchasers into a system — may result in nothing more than rounds of competitive price wars with limited market share gains, the authors warn.

Such an approach simply allows providers to avoid dealing with the real problem, which is costs — not pricing, they say.

Instead of merely slashing prices, the authors suggest PPOs need selective medical staff recruitment, strict utilization review, and alternative delivery systems in order to succeed. In addition, they strongly recommend taking a new approach to identify, analyze and manage the cost of hospital services, which they term the most difficult yet most important aspect of cost management.

This approach includes redefining hospital "products" from units used in the past (patient days, surgical hours, diagnostic tests and ancillary services) to "end products," such as the normal delivery of a baby. These end products may then be broken down into component parts in order to determine costs.

Development of this information serves as the base for cost effective product management and allows the provider to compete profitably, the authors say. The method also results in three key outputs: actual costs for hospital products are determined; specific cost reduction opportunities are identified and action plans are developed; and ongoing in-house capabilities and organizational relationships for managing costs are established.

"To succeed, a PPO provider must commit to reducing costs through the use of sophisticated management techniques, the authors say, rather than simply cutting prices in hopes of bringing new patients into their facilities.

Calcium Blockers May Prove Effective for Migraines

Diltiazem, a "calcium blocker" drug developed for the treatment of heart disease, may also prove effective as a remedy for certain stubborn forms of migraine, two department directors at the University of Cincinnati Medical Center recently discovered.

Robert Smith, MD, director of the U.C. Department of Family Medicine and of the Headache Center, and Arnold Schwartz, PhD, director of the Department of Pharmacology and Cell Biophysics, recently combined their knowledge, experience and skills by conducting a study of nine headache patients and treating them with the drug. Early results were published in the correspondence section of a recent issue of the *New England Journal of Medicine.*

The study was initiated following Dr. Smith's search for a drug to treat patients suffering from "refractory" migraines which traditionally have not responded to the "beta blocker" drugs used to treat other forms of migraine. In addition, patients suffering from asthma, heart disease or diabetes cannot be treated with traditional migraine drugs, nor can those who suffer unpleasant or dangerous side effects from them.

Because diltiazem and other calcium blockers have proven successful in opening narrow and blocked blood vessels in heart and vascular disease, the researchers surmised they might have the same beneficial effect on brain blood vessels thought to constrict in some migraine cases.

"It's early yet," Dr. Schwartz says, "but we think there is a similarity between spasms that occur in blood vessels in heart disease and those that occur in the blood vessels in some kinds of migraine. If that's true, calcium blockers may have tremendous value for hundreds of thousands of people suffering from a condition we haven't known how to deal with."

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Highlights of '84 The OSMA Annual Meeting

"DRGs: The Changing Face of Medicine" was this year's Annual Meeting theme, and medicine's changing face was evident on more than one occasion as resolutions were presented for the delegates' consideration. The meeting began on . . .

Friday Night

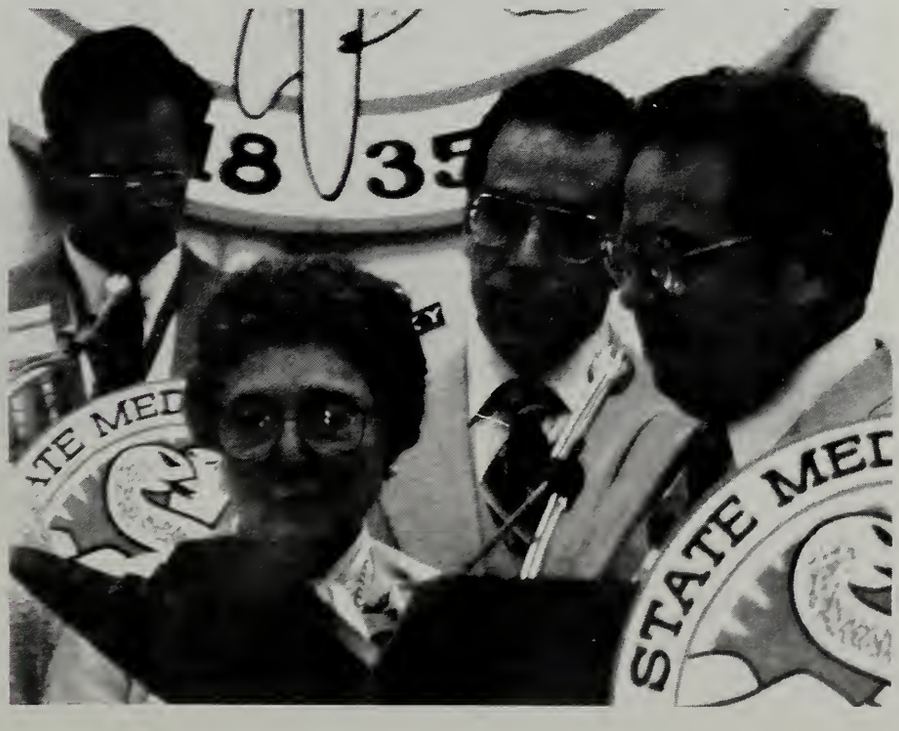
William Gates, President of the Academy of Medicine of Cincinnati, welcomed all those attending the House's opening session to the "Blue Chip City."

President S. Baird Pfahl, Jr., MD, then steered the meeting through presentations of reports and awards — including Distinguished Service Citations presented posthumously to Perry R. Ayres, MD, and Milton Parker, MD, both from Columbus, for their work on the Impaired Physicians and Mental Health Committees respectively; and special awards to John Burkhart, MD, Columbus, for his service as president of the Occupational and Physical Therapy Board, and to Oscar Clarke, MD, Gallipolis, for his service as president of the Ohio State Medical Board.

In his Presidential Address, Dr. Pfahl mentioned that OSMA Executive Director Hart Page would be retiring after the end of next year.



A. Burton Payne, MD, presents Mrs. Ayres with the Distinguished Service Citation awarded to her husband, the late Perry Ayres, MD.



Right: Mrs. Milton Parker accepts a Distinguished Service Citation from Dr. Payne, on behalf of her husband, the late Milton Parker, MD. A member of the Parker family looks on, as does OSMA Immediate Past President, S. Baird Pfahl, MD (left).

Friday Night

continued



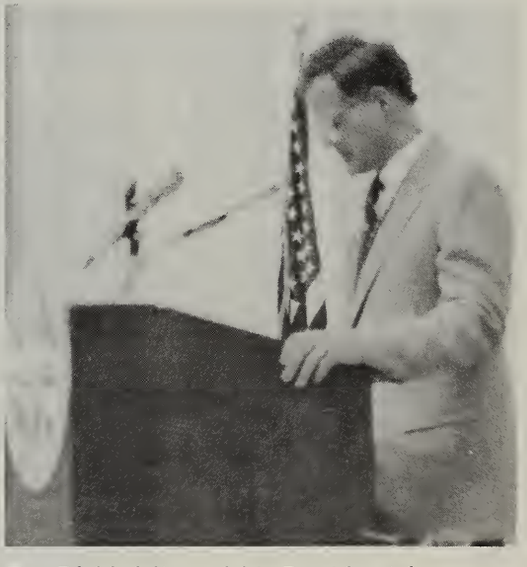
John Burkhart, MD, Columbus, receives recognition for his service as President of the Occupational and Physical Therapy Board from President-Elect A. Burton Payne, MD.



Oscar Clarke, MD, Gallipolis, also received a plaque for his service as President of the Ohio State Medical Board. Dr. Payne presented the award.



Philip B. Hardymon, MD, Columbus, dispenses the AMA-ERF checks, assisted by Stella Brown, the OSMA Auxiliary's Immediate Past President.



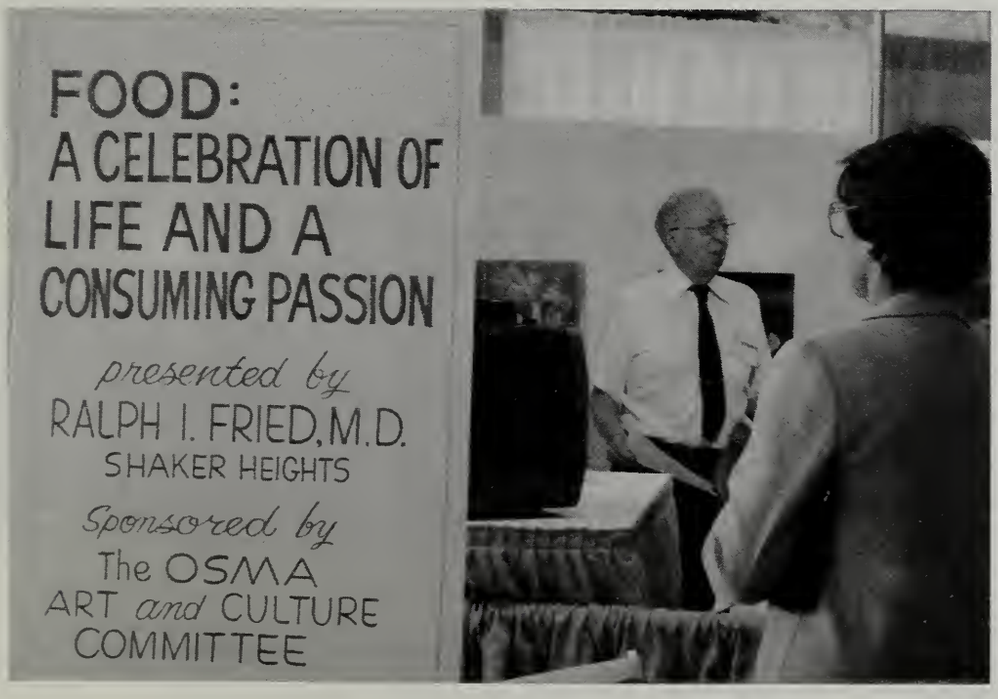
Dr. Pfahl delivered his Presidential Address at the end of the Opening Session.

Saturday

While reference committees listened to testimony on the resolutions assigned them, other delegates were able to take advantage of the Resource Center (PACO even provided a computer demonstration); the Art and Culture Committee's exhibit on "Food: The Consuming Passion"; as well as some of the meeting's social activities, like the OMPAC Luncheon, with guest speaker Douglas Kiker, and the dinner cruise down the Ohio on the riverboat "Becky Thatcher."



C. Douglass Ford, MD, Toledo, Immediate Past President, enjoys remarks made by OMPAC speaker Douglas Kiker during the OMPAC Luncheon.



The Art and Culture Committee sponsored an exhibit, "Food: A Celebration of Life and a Consuming Passion," assembled by Ralph Fried, MD, Cleveland, pictured on the left.

Sunday

The House reconvened to consider the resolutions discussed on Saturday — and to take care of other business . . . such as announcing the OSMA's new President-Elect — Herman Abromowitz, MD, Dayton.

After the elections, and the committee reports were heard, Dr. Ford installed A. Burton Payne, MD, Ironton, as the new President of the OSMA.



President-Elect A. Burton Payne presents the Past President's pin to Dr. Pfahl. Mrs. Pfahl (extreme left) was installed as OSMA Auxiliary President earlier during the convention.



Herman I. Abromowitz, MD, Dayton (left) was named the OSMA's new President-Elect. William Marshall, MD, Dayton (right) will replace Dr. Abromowitz as Second District Councilor.



The OSMA's leaders are pictured, left to right: S. Baird Pfahl, MD, Immediate Past President; C. Douglass Ford, MD, Past President; David Barr, MD, Secretary-Treasurer; Herman Abromowitz, MD, President-Elect; A. Burton Payne, MD, President; and Hart Page, OSMA Executive Director.



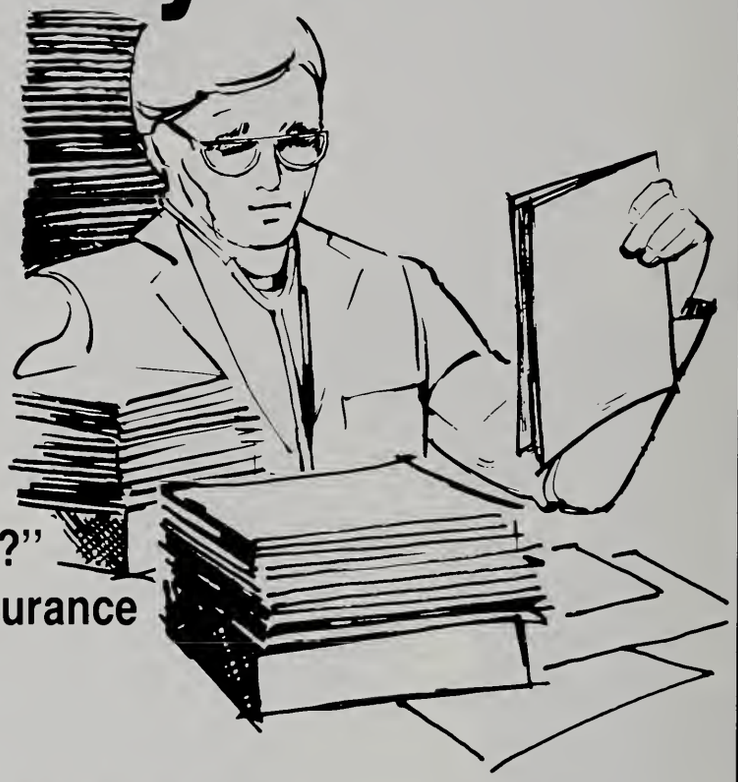
Dr. Ford installed A. Burton Payne, MD, as OSMA's new President.



Dr. Payne addressed the House in his new role as President.

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Drug Capsules

* **Cefonicid** (Smith, Kline & French Laboratories) is a new, long-acting antibiotic recently approved by the Food and Drug Administration. Because it acts for up to five hours in the patient (instead of minutes as do current antibiotics), a single daily injection works as well as four daily injections of current agents. If cefonicid catches on, and it will be widely advertised, it will cut the costs of administering antibiotics in hospitals and make more patients eligible for treatment as outpatients. This will have a major impact on health care costs — one study estimates that as much as $277 million could be cut from the nation's hospital bill if the drug is used sufficiently widely.

* **Urocit** (Mission Pharmacal) is one of the so-called orphan drugs which the FDA is getting ready to approve. The drug is potassium citrate, and will be used to help prevent the formation of some types of kidney stones, and thus avoid the need of surgery.

* **Motrin and Rufen,** the brand names for the popular painkiller ibuprofen, will soon be available as an over-the-counter drug. The FDA recently approved non-prescription marketing of the drug, which will be labeled for temporary relief of aches, pain from menstrual cramps, and fever reduction. Manufacturers say the drug causes less stomach irritation and less risk of overdose than aspirin. One product, produced by Upjohn Company, and distributed by Bristol-Myers, will be called Nuprin. A second product, marketed by Whitehall Laboratories, will be sold as Advil.

This section is being introduced into the Journal to help keep you, the physician, informed of new products, trends and developments in the drug industry.



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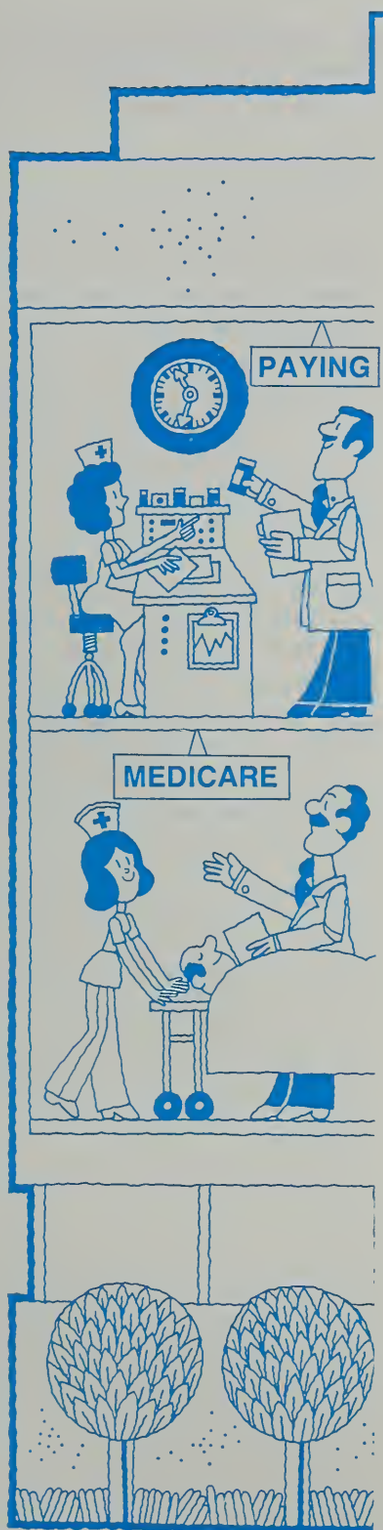
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A Fork in the Road of Medical Care

Is a Two-Tiered Health Care System Just Around the Bend?

by Susan Porter

When Colorado's Governor Lamm purportedly suggested the nation's health care bill be trimmed by cutting care to the chronically ill elderly, nearly all segments of the health care arena were outraged — yet stumped. Consumers, providers, industry, government and third-party payers, alike, saw the proposal as extreme and inhumane. Yet at the same time, all were forced to recognize that a substantial number of health care dollars are spent simply sustaining the final 12 to 18 months of life — which, in hindsight, appears to place an undue burden on the already severely overtaxed Medicare system.

The proposal represents one of several "extreme approaches" to solving the problem of spiraling health care costs, Lee McHenry, MD, immediate past president of the Ohio Society of Internal Medicine told fellow physicians at a recent seminar called "A Fork in the Road of Medical Care — The Two Faces of Medicine."

One of several specialty society and section programs held in conjunction with the OSMA 1984 annual meeting this past May, the seminar featured a panel representing various segments of the health care community who discussed the current pressures leading towards a two-tiered system of health care in this country: one level of care for those who can afford to pay; another for those who cannot.

Another "extreme" approach not likely to win any popularity contests is one Cincinnati physician's suggestion that Medicare be eliminated and replaced with a flock of physicians hired by the federal government to treat the poor and elderly.

While neither extreme is likely to be

"There are multi-tiered restaurants for food — some go to the Maisonette; others eat at McDonalds. We all drive different cars. There is nothing wrong with tiers, as long as the bottom tier is adequate."

implemented, Dr. McHenry said in introducing the panel, the "pressures (towards a two-tiered system) have been increasing over the years — the (cost) concept weaves in and out of all other socio-economic aspects of health care.

"When Medicare and Medicaid were originally debated and passed, one of the chief concerns was that patients be maintained in the mainstream of medicine," Dr. McHenry said. However, he continued, "we are now spending over one billion dollars a day in this country for health care. It is obvious that some things are going to have to give."

Most of the panel — which included Thomas C. Nelson, coordinator of consumer affairs for the American Association of Retired Persons (AARP); William M. Copeland, president and chief executive officer for St. Francis-St. George Hospital and Health Services in Cincinnati; William J. Marshall, MD, a Dayton internist and cardiologist and the new second district councilor to the OSMA; Bonnie Brown, legislative aide to Congressman Willis D. Gradison in Washington; Joe Jacobs, resident comptroller of General Motors Assembly Division; and Richard A. Thompson, vice-president of the Consumer Medical Cost Containment Corporation of Cincinnati, a third-party administrator of health care benefit packages — agreed.

Yet just *what* should give and *who* should give it was much more difficult to discern, as each panelist gave his or her views on the situation and what could be done to remedy it.

Many of the panelists contended that a two-tiered or multi-tiered system need not be all bad, as long as adequate care is available to individuals at all levels. Most realized, however, that the American public is not yet ready to talk about two levels of care — much less accept it.

"When you talk to the public about rationing, they get indignant," Copeland commented early in his presentation, adding his view that rationing — "a lot of rationing" — is an inevitable part of health care's future. "We get indignant, yet we're not willing to pay more for it."

The Consumer's View

Not all panelists agreed that two-tiers of care were acceptable. Among them was Nelson who told the audience that the AARP represents some 16 million older Americans — "the ultimate health care consumer."

"Our position is — yes, there are some very clear financial pressures for a two-tiered medical system," Nelson said. "But what can we do to fight it?"

Adopting the slogan, "Cut the Cost — Keep the Care," the AARP has "identified the health care crisis as the number one priority for our organization this year," he said. "Our view is that the cost escalation is virtually out of control and the situation is not improving. Recent voluntary efforts to slow down costs have not worked."

However it is not the elderly who should bear the brunt of financial cutbacks to health care programs, Nelson contended. "A myth that is most troubling to us and our membership is that the elderly are somehow insulated from rising costs, when they are in fact more vulnerable to them."

The elderly patient, Nelson went on to say, currently pays one-third of his/her own health care bill averaging $1,500 in out-of-pocket expenses a year, or 15% of his/her fixed income. "If the cost of health care continues to rise at the current rate, by 1995 the bill will be over $7,000 — over 40% of the older person's income."

With Ohio's Medicaid program now being considered for major cutbacks and the federal Medicare program faced with bankruptcy by the end of this decade, "those most in need, no doubt, will bear a significant portion of this attempt to reduce costs," Nelson said.

However, the AARP is "attempting to mobilize our membership to get legislatively active. Our message to policymakers is: we need to look at

this deficit as something that is system-wide in the health care delivery system — not just (created by) Medicare."

Rather than cut benefits, shift costs or increase payroll taxes to save the Medicare program, the AARP is urging state and federal representatives to mandate cost controls in the health care industry, according to Nelson. "Across the board, our research tells us that 80% of the public supports a regulatory mechanism," he said. "DRGs are a step in the right direction, but if limited to Medicare, they will only contribute to a two-tiered system."

The Providers' Views

Taking a diametrically opposing view to the merits of DRGs — which, in his estimation will force some 1,000 hospitals to close over the next decade — was William M. Copeland, president and CEO of a Cincinnati hospital which serves a high percentage of Medicare patients. Yet Copeland agreed that something has to be done or rationing of health care resources will be inevitable.

"Without intervention, rationing will occur on an economic basis," Copeland said. "There is all kinds of health care available to those who can pay for it. But if you don't have the money, you won't be able to get it. You obviously are going to have two-tiered care."

Unlike Nelson and some other panel members, Copeland did not think a two-tiered system was necessarily unacceptable. Comparing health care services to other services and products, he said, "There are multi-tiered restaurants for food — some go to the Maisonette; others eat at McDonalds. We all drive different cars. There is nothing wrong with tiers, as long as the bottom tier is adequate."

Similarly, panel member William Marshall, MD, who has practiced medicine for the past 25 years and serves as a member of the Dayton Business Coalition, contended, "We've always practiced multi-tiered medicine in America." Reviewing the history of medical care in this country from the 19th century to the present time, Dr. Marshall noted that while the poor have traditionally been used for teaching purposes, the rich often have served as the major source of revenue; thus each group has received a different kind of care.

More recent efforts to upgrade health care services for the elderly and poor (which according to Dr. Marshall should not always be lumped together), along with advances in research and technology, expansion of health care benefits through business and industry and subsequent increased use of medical care and facilities may be causing the system to "spin out of control," in Dr. Marshall's words.

"We need to take a very pragmatic approach to the situation," he told fellow physicians. "If we choose to impose effective limits, a multi-tiered system is bound to continue. DRGs have simply created another layer."

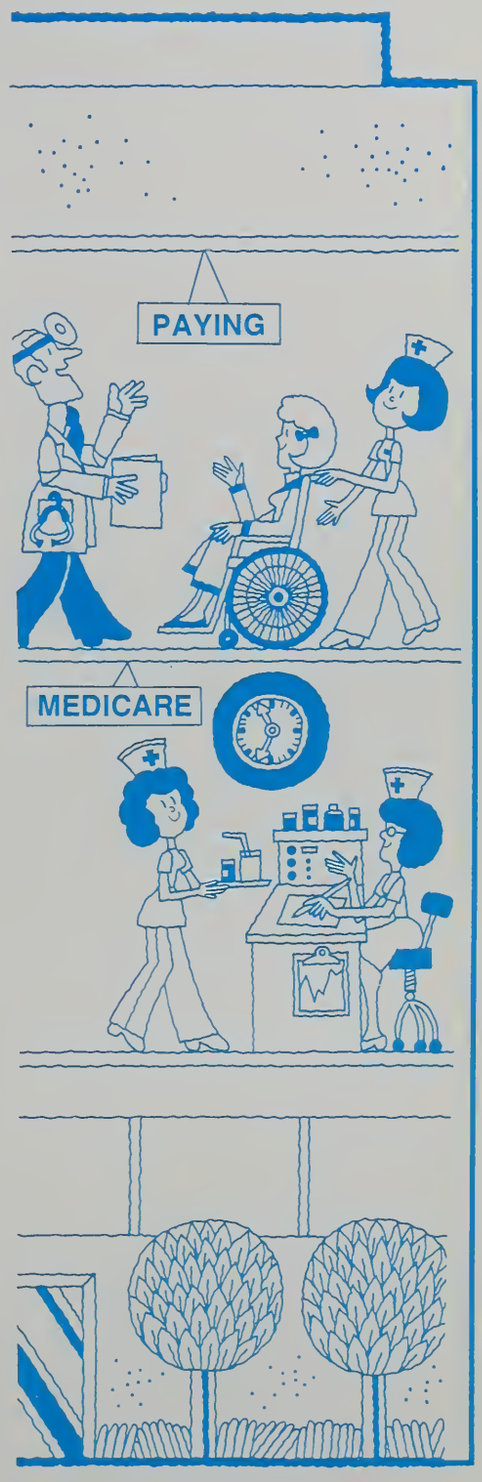
Government's View

Another panelist not directly opposed to different levels of care was Bonnie Brown, legislative aide to Congressman Willis D. Gradison in Washington. While most "Americans seem to expect a Rolls-Royce level of medical care," there are others getting no care at all, Brown said.

Brown, who gave the federal government's view of the dilemma, referred to a recent Robert Wood Johnson Foundation report which indicated that some 28 million Americans still don't have adequate access to health care services. "Most Americans have access to large numbers of health care specialists," she said. "However access is limited to some segments of the population, including the poor, the uninsured, the unemployed, and the uneducated."

Calling 1983 a critical year for Medicare because "it was the first year that more money went out than came in," Brown indicated that a two-track system of health care may not be undesirable.

continued on page 525



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INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient, but there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses [illegible] than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

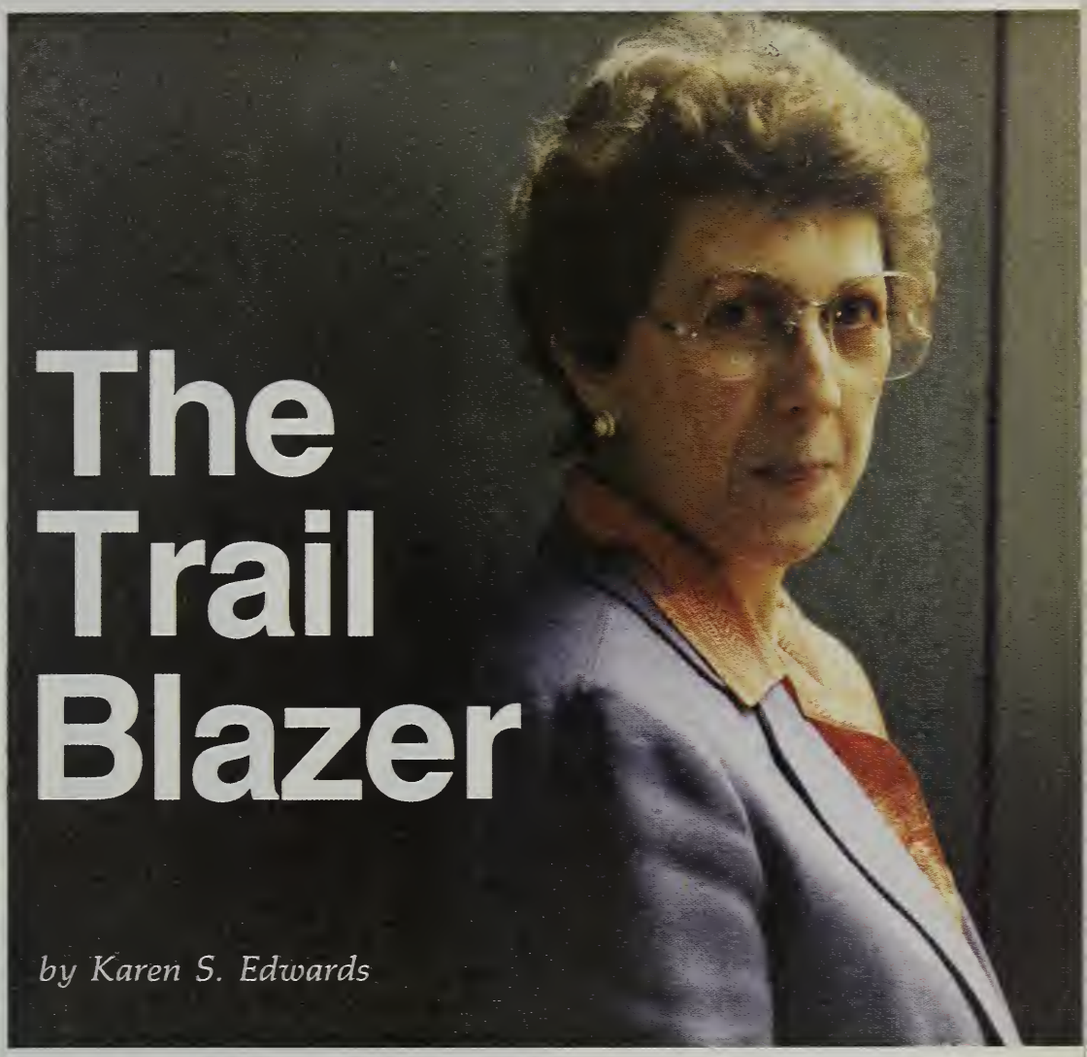
HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

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The Trail Blazer

by Karen S. Edwards

For the first time in the history of the Ohio State Medical Association, a woman has been elected to sit on its Council. It's a giant step forward, but one which a woman and physician like Dr. Nermin Lavapies takes right in stride . . .

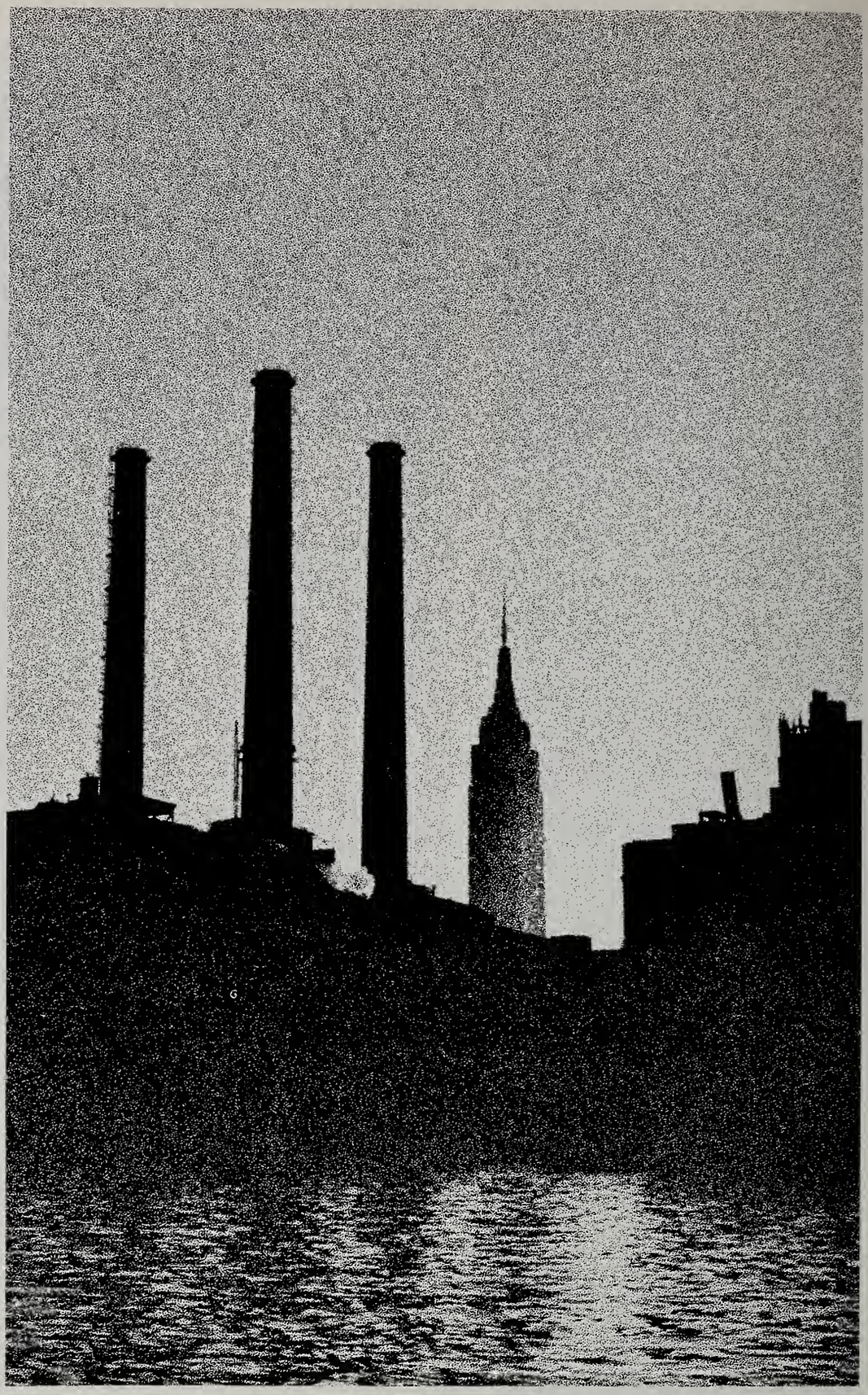
No one would have ever called it easy.

Society still had its prejudices, harbored like moths in a closet, needing only a ray of light to send them fluttering away. The time, the light was coming . . . but it was still lost in the shadow of the fifties.

It was a world of choking smoke stacks and steel hats and chronic coughs that Nermin D. Lavapies, MD, entered during that era. As a foreign exchange medical student from Istanbul, Turkey, sent to intern in the tough steel and mining town of Wheeling, West Virginia, Dr. Lavapies found that area as foreign to her as she was to it.

"It was a different culture," she says. "A different view of things."

Despite her native country's tendency to place women directly behind their husbands in matters of importance, treating them, in essence, as "second class citizens," a woman physician is no more remarkable in that country than stale air down a mineshaft.



It was a world of choking smoke stacks and steel hats and chronic coughs that Nermin D. Lavapies, MD entered during that era.

The Trail Blazer

continued



"One-third of my medical school's graduating class were women," she says. "And you'll find that women in medicine are not unusual in third-world countries. Higher education in Turkey is free. The family does not have to sacrifice the daughter's education to pay for the son's."

Dr. Lavapies had known from high school that she wanted to pursue a career in medicine — though she can't tell you why.

"My father was a mining engineer and very well educated. My mother was French, and she never accepted herself as a second class citizen. She wouldn't let me accept that role either.

"I knew early that I wanted a profession. For me, it represented a means of independence — of choice."

The choice brought her to America, to Wheeling, but the beginning was tough. By nature of her birth she already had two strikes against her, at least as far as the Wheeling community was concerned. She was foreign-educated, and she was female. The fact that she was working in an Emergency Room when emergency medicine was just getting off the ground was like swinging the bat and hearing the umpire shout "Strike Three."

"I was one of the first persons to be hired to work in Ohio Valley General Hospital's ER," Dr. Lavapies recalls.

In fact, she organized the department and kept it going until four other physicians could be hired to help out.

"In the early days, the ER was very much like outpatient care," she says (which goes to show everything eventually comes full circle.)

"There were always a large number of highway accidents in that area, and with the steel and mining industries so close, we always saw a number of head injuries."

Coronaries, however, were the number one problem.

"We didn't know very much then about coronary care. People came in and fibrillated, and that was it. There was little technology to depend on."

It was a frustrating time for everyone in emergency medicine — and certainly for the soft-spoken young woman from Turkey, who had other frustrations with which to deal.

"It was difficult for me to gain acceptance in the community — but I'm not sure what held me back more — being a woman or a foreign medical graduate," she says.

She recalls an incident that happened one day in the ER. There had been an auto accident. The victim was brought in with a laceration that needed to be stitched. As Dr. Lavapies set to work, the patient — a man — eyed her up and down. Then, he grunted, "Well, I'm glad I got you and not one of those foreign doctors." Dr. Lavapies never blinked an eye. She kept right on stitching.

There are other stories — some better, some worse. In some cases, patients would actually refuse care from her. But nothing discouraged her.

"After several more years doing general practice work at the hospital, I finally realized that hospital work was not for me. I wanted to get out among the people, in my own practice."

She took her medical boards in 1968 (she was required to become a U.S. citizen to qualify for her board exam), then moved across the river to tiny Martins Ferry, Ohio, a community not unlike the one she had left.

"It is largely a mining community of about 10,000 people," Dr. Lavapies explains. "Unemployment in the area is 15%-16%, still one of the highest in the state."

So it is consequently an elderly community.

"The younger people can't find jobs, so they leave the area," she says. "People still hope that the Wheeling/Pittsburgh steel mills — one of the biggest employers in the area — will make a comeback and revive the economy. But it is doubtful if the mining industry can do the same. Mining may never be the industry it once was."

Because unemployment has always been a problem in the area, the local county medical society did not have to

"I knew early that I wanted a profession. For me, it represented a means of independence — of choice."

By nature of her birth she already had two strikes against her . . . she was foreign-educated, and she was female.



At right, Dr. Lavapies stands with OSMA's Immediate Past President, S. Baird Pfahl, MD. At bottom, Dr. Lavapies in action at the House of Delegates, with 12th District Councilor Joseph L. Kloss, MD, Akron.



do any structuring of programs for the unemployed, the way some counties did.

"We've been taking care of our unemployed for years. This is not a new problem in our area. With the decline of the coal mining industry, and the number of strikes in both steel and mining, we have always had families employed, then unemployed, then employed again. They stuck with us, and we stuck with them."

The problems she sees in her practices are still largely chronic respiratory problems. But cancer is the area's most persistent enemy.

"Whenever we see a patient, we have to entertain the fact that he or she may have cancer. (Dr. Lavapies is in practice with her husband, also a family practitioner, and also foreign-educated. He is originally from the Philippines.)

"Our surgeons become very depressed having to deal with it all. In fact, we all sort of cheer when we find there is no cancer."

Dr. Lavapies joined the county medical society in 1970, and became an active member almost immediately.

"I was urged into membership by Dr. Bertha Joseph who was one of the early feminists. She was a graduate of the Women's Medical College in Philadelphia and she did birth control counseling as early as the 1930s.

"Dr. Joseph really put Belmont County on the map. She got to know the OSMA staff and began to bring state issues back to the society. She urged the participation of local physicians in state legislative issues and processes."

Dr. Lavapies became Dr. Joseph's pupil, her protege. She, herself, became involved in the OSMA's "key physician" legislative program, and became active in the Ohio Academy of Family Physicians (OAFP), serving on its Committee on Minority Affairs. After all, as a physician who has blazed her share of trails, both as a woman and a foreign medical graduate, what better position is there from which to share her valuable experiences and insight?

Politics interested her, too.

"Even though Belmont County is closer to Wheeling and Pittsburgh, we knew that their politics were not *our* politics. We had to turn our membership around, and interest them in what was going on in Columbus and Ohio. So, we made a point of seeing our local legislators frequently, and inviting them to our meetings."

At about this time, Dr. Lavapies was serving as the county society's secretary-treasurer.

"When I met Dr. Joseph, she held the position, but was in poor health and didn't want to serve in that capacity much longer. Before she left the position, however, she recommended me for the job, and she recommended to me that I take it."

It was a step forward, and one she has no regrets taking. Her involvement with OAFP brought her yet another step forward, as it introduced her to H. Judson Reamy, MD, a fellow family practitioner from Dover who was serving as OSMA's seventh district councilor (Board of Directors). He was the one who urged Dr. Lavapies to run as his replacement.

Belmont County had never produced a councilor before — let alone a woman councilor — but can a trailblazer ever resist one more trail?

"Dr. Reamy had frequently brought caucus meetings to our area to discuss the current issues. When he first approached me about running for councilor, I didn't know what to think," she confides.

Belmont County had never produced a councilor before — let alone a woman councilor. Some past presidents had come from the county, but never a councilor.

Can a trailblazer ever resist one more trail? She discussed it with her membership and decided to run. At this year's Annual Meeting in Cincinnati, the title was officially hers. And, it was officially noted, she is the first woman in the 149 year history of the Ohio State Medical Association to be so honored. The time, the light had come.

"Medicine has come a long way in accepting women," she says, and adds, "So have the patients."

Dr. Lavapies currently has a niece in medical school, and she derives some satisfaction from the fact that she has laid some of the groundwork for her niece and other women in medical school who wish to become more involved in organized medicine. But she has concerns about the direction medicine is heading, and where it will eventually land all medical students, male and female.

"This generation is facing a totally different situation in medicine than I did. Years ago, you were your own boss. Now, there are more controls. In the past, there were some patients and physicians who did overutilize and abuse the system, so regulation is not altogether bad. But the way it's going is scary. I'm worried about where we will be ten years from now. The younger group seems to be much more adaptable to the way things are being done now, but they've never practiced any other kind of medicine. And who knows what else the state and federal government is planning for us?"

What advice would she give her niece and other medical students?

"Practice good quality medicine always — and be a patient advocate. Sometimes we forget patients have feelings."

Dr. Lavapies occasionally takes a local college's continuing education course in philosophy, just to keep herself aware of the moral and ethical side of medicine — a side which is just now beginning to have more and more significance, what with medicine's ongoing scientific and technical advances. And somehow, it just figures that Nermin Lavapies — woman, physician, councilor, trailblazer — would be in on the ground floor. **OSMA**

Karen S. Edwards is Executive Editor of the **Ohio State Medical Journal.**



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL LA** (PROPRANOLOL HCl) *LONG ACTING CAPSULES*



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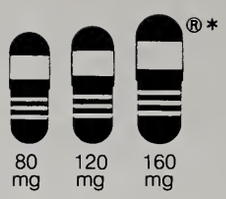
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JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

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"Two-track care may be different, but it doesn't have to be inferior to mainstream medicine," she said, particularly if "it can be tailored to the special needs of the poor and underserved."

Industry's View

Perhaps expressing the greatest opposition to two-tiered care was Joe Jacobs, resident comptroller at GM, who related that health care benefits for GM employees represent $400 of the sticker price of a new GM car. While industry, also, is anxious to curb rising health care costs, "As a matter of policy, we cannot sustain a two-tiered system," Jacobs said, "In my opinion, it is not morally correct to do so."

Yet business and industry have major stakes in keeping health care costs down. Jacobs pointed to the nation's health care budget which now represents over 10% of the Gross National Product, making the health care industry the second largest in the nation, next to food and food processing. He also referred to the $2.2 billion GM paid out for health care coverage for its employees in 1983 — which represented a 50% increase over five years for the company — among reasons "our industry is getting involved in your industry."

"Industry has an obligation to understand your business," he continued. "Health care costs are not 'fringe' costs anymore."

Yet Jacobs was quick to recognize the multi-faceted aspects of the rising health care bill, listing the aging population, unhealthy lifestyles, society's demands for high quality care, defensive medicine, the modernization of hospitals, new technological developments, the growing supply of physicians and the implementation of Medicare/Medicaid among its causes.

"My understanding is that 30% of the health care bill is created by the practice of defensive medicine and the purchase of malpractice insurance. I've heard there are physicians paying up to $80,000 in insurance — with a clear record."

He also blamed the health care industry for inadequate planning, then went on to list the plans industry is making to curtail future increases. These include data bases to determine high cost areas, requiring employees to get second opinions for elective surgery, the formation of business coalitions, the adoption of "wellness" programs, the establishment of deductibles and copayments in benefit packages, the exploration of alternative delivery systems and generic drug programs, and the support of substance abuse day treatment programs, ambulatory treatment programs and other alternative delivery systems.

Adopting the slogan, "Cut the Cost — Keep the Care," the AARP has "identified the health care crisis as the number one priority for our organization this year."

The PPO as a solution

Among other panelists to offer solutions was Richard Thompson, vice president of Consumer Medical Cost Containment Corporation of Cincinnati, a third-party insurance administration company which recently implemented a preferred provider organization (PPO) in Cincinnati.

"Competition between government and private enterprise will be sorely tested over the next few years," Thompson warned. "One Cincinnati hospital will lose $1.5 million its first year under DRGs. It's only alternative is to shift costs to other patients."

One way for other third party payers to avoid paying for this cost shift is through PPOs, which allow business and industry to negotiate with health care providers for their services. In order for a PPO to be successful, however, physicians "motivated to contain costs — dedicated to the proposition that costs must be controlled if free enterprise in health care is to survive" must be recruited, Thompson said.

Other factors contributing to the success of a PPO include competent claims processing and prompt payment to providers; an active medical advisory board to handle preadmission certification, utilization review, post auditing, etc.; careful selection of cost-effective hospitals as members; and implementation of wellness programs designed to promote positive changes in lifestyle and avoid high health care bills later.

"To avoid further government regulation, doctors need to cooperate with us to keep health care costs down," he said.

In fact, all panel members in one form or another asked physicians for their assistance in making sure high quality care will continue to be available to all citizens — but at an affordable price.

Jacobs, who said he feared two-tiers of health care will mean "quality care for the wealthy; neglect of the elderly," told physicians at the seminar, "Your industry is under siege, not unlike mine. The cost of health care is a problem of such magnitude that everyone will have to work in order to bring it under control."

Others, like Copeland, maintained that two-tiered care is an inevitable part of the solution but can work, "if we have a decent minimum standard of service on both tiers." **OSMA**

Susan Porter is Assistant Editor of the Ohio State Medical Journal.



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DOUGLAS KIKER
Live, Remote, and On-the-Air

by Karen S. Edwards

Maybe not everything you wanted to know about current events was covered at this year's Ohio Medical Policial Action Committee (OMPAC) Luncheon, but certainly everything you might want to know about those *reporting* current events was revealed by OMPAC speaker Douglas Kiker.

Kiker, a television news correspondent and Peabody Award Winner, who has provided reports for "NBC Magazine with David Brinkley," and is currently serving as Washington correspondent for "NBC's Today Show," regaled the audience with accounts ("all of which are true," he swears) of his colleagues' on-the-air reporting skills, including enough bloops, blunders and faux pas to qualify for a television show.

Still, between the stories, are glimpses of life as a political reporter — and the fact that *covering* current events can, at times, be as difficult as *creating* them.

"We recognize that the public doesn't always trust television reporters," Kiker says. "And the fact is, we really don't have enough time to give *all* the news to the public."

When one discounts the amount of commercial time in any 30-minute news broadcast, only 22 minutes are available to the reporters — and field correspondents will literally fight for those all-important seconds."

When one discounts the amount of commercial time in any 30-minute news broadcast, only 22 minutes are available to the reporter to tell his or her story — and field correspondents will, literally, fight for those all-important seconds.

Kiker summed up the situation in his own humorous style:

"If we were reporting on the ten commandments, we would have to reduce the story to the most important three."

Part of the difficulty of being a TV news correspondent, Kiker claims, is the fact that television is a state-of-the-art medium.

"Every year, better and newer technology is introduced so that the news can be brought to you faster — but, note, I didn't say better," he says.

As a result, "we're not always able to be as accurate as possible," Kiker explains.

According to Kiker, one of the prime reasons for mistakes is the "live but remote" broadcast.

"While you're out in the field, waiting for the cue that you're on the air, you spend too much time thinking. You think 'Was that William A. or William J? Is he Marshal or Deputy Marshal?' By the time you're cued, you've made yourself so confused you're not even sure what's accurate anymore."

Kiker is quick to point out, however, that each correspondent writes his or her own story. "There is no platoon of writers standing at our elbow."

What kind of insights has Kiker been able to draw out of twenty years of political reporting?

"A lot of things have changed," he says. "For example, the recent proliferation of presidential primaries. They are the reason for the non-stop presidential campaigning that goes on now. It seems like each presidential campaign lasts four years."

The primary explosion is also directly accountable, he claims, for changing the character of the conventions (And Kiker should know. He's covered every national presidential convention since 1964.)

"There is no excitement at conventions anymore. All they do is ratify a choice that's been made months before. You're just not going to see the Wendell Willkies or Adlai Stevensons anymore. There are simply not the choices there once were at these conventions."

As a result, Kiker says, you're beginning to see more and more independent voters.

"They now constitute one-third of the electorate, and their power is becoming greater. In the 'swing states' — which include Ohio — no presidential candidate has ever won without the support of the independents."

And being president today is no picnic, Kiker will tell you.

"The American public and especially the news media want to kill the president before he's given a chance. They give the President two years to prove himself, and if he hasn't pleased everybody all the time, he's voted out

Herman Abromowitz, MD, Dayton, listens to OMPAC speaker Douglas Kiker, at the OMPAC luncheon, held during the Annual Meeting in May.



in two years. Look at the facts. There has been no two-term president since FDR. There is no respect for the presidency anymore."

The economic recovery, however, may lift some public spirits, he says.

"Recovery is zipping along, and national morale right now is very good. But we still have a long way to go before we fully recover from the recession. What we do with the sixteen years we have left in the 20th century are crucial."

Kiker is optimistic, however.

"Our country is not out of control — but we have some hard realities to face."

He points to the energy problems, and the need to reverse the American worker's productivity trend.

"We need to start making *better* products than the Japanese.

"But don't tell me that we aren't rich enough, or imaginative enough to take care of our own problems. Of course it may take some time to get our house back in order, and frankly, some small towns may never be the same again. But," he peers over the podium and makes eye contact with the audience, "our country is tougher than you think it is. Just think what it's been through in the last ten years. Why, political terrorism is accepted now, as a common occurrence. But American pride, determination and energy still exist. There is no problem today that we can't solve."

In referring to Ronald Reagan, Kiker says that the optimism he brought into the office was a tonic.

"But now, we're standing at an economics crossroad, where signs of trouble are beginning to overshadow the optimism. We're practicing 'bite-the-bullet' medicine to take care of deficit spending. Compromise is the order of the day — but postponement is what you'll see."

Still, America *will* recover, Kiker says.

"We're the Timex of nations. We take a licking and go on ticking."

Economic recovery will continue, as will Reagan's popularity.

"Reagan won't be nominated at the Republican convention — he'll be coronated," Kiker predicts tongue-in-cheek.

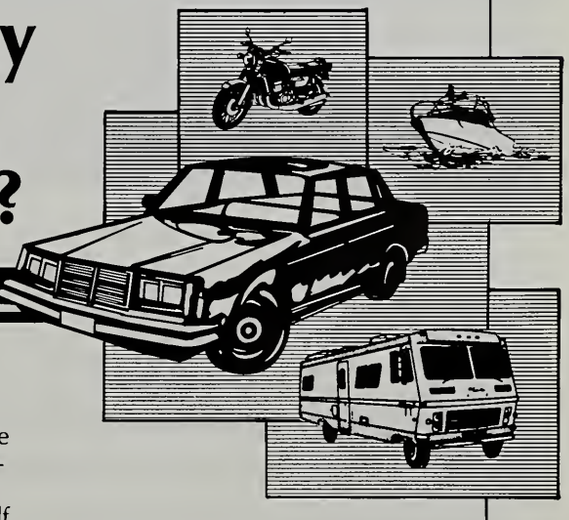
"The Democratic winner is going to be Walter Mondale, and he's going to turn out to be a mirror image of Reagan," Kiker says. "And the election is going to be close — a real cliff-hanger. There will be a big voter turnout in '84. You'll see more blacks and blue-collar workers voting this election. It's doubtful that Reagan can get the independent vote, but you wait and see. This November, you'll be glued to your TV set until early in the morning."

And, no doubt, Douglas Kiker will be there to report all of it to you — live, remote, and on-the-air. **OSMA**

Karen S. Edwards is the Executive Editor of the Ohio State Medical Journal.

" . . . Don't tell me that we aren't rich enough, or imaginative enough to take care of our own problems. Of course, it may take some time to get our house back in order, and, frankly some small towns may never be the same again."

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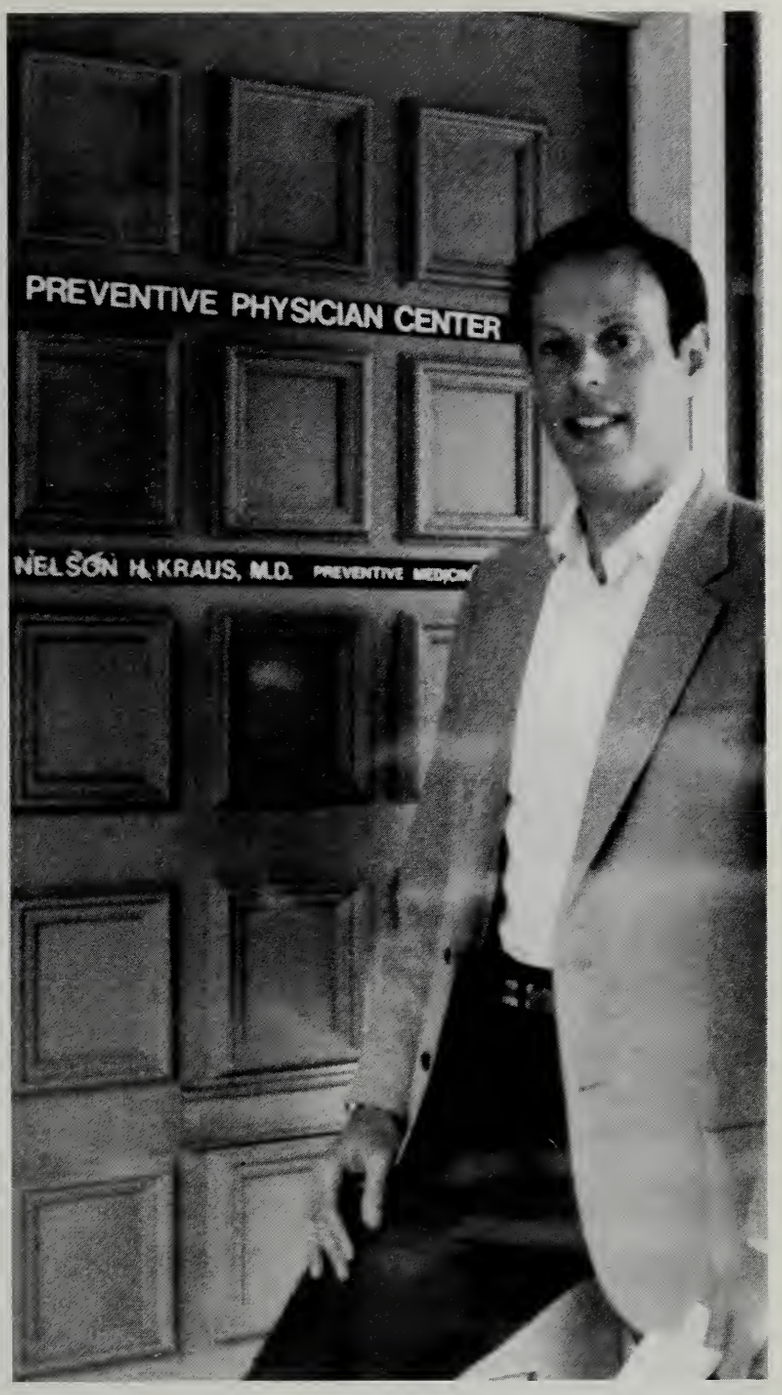
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Medicine's Master Marketeer

By Susan Porter



Nelson H. Kraus, MD, is enjoying a booming business after opening his private practice in preventive medicine just two years ago. He predicts a growing number of professionals will soon be joining him in the ranks of preventive medicine.

He is one of only two physicians listed in the Columbus area yellow pages under "Preventive Medicine" — an area sometimes regarded with raised eyebrows by fellow colleagues who, in his words, consider it a "poor stepsister" of the medical profession.

But Nelson H. Kraus, MD, is enjoying a booming business after opening his private practice in preventive medicine just two years ago, while other physicians in more highly regarded specialties — surgery, ophthalmology, internal medicine, radiology and urology — watch their patient loads steadily decline. And he predicts a growing number of professionals will be joining him in the ranks of preventive medicine, as the medical profession undergoes some tremendous changes in the way it solicits and treats patients.

"The private practice of preventive medicine is a fairly new area," says

The present health care system is totally structured around all the king's horses and all the king's men, trying to put Humpty Dumpty back together again. We (in preventive medicine), on the other hand, are attempting to deal with Humpty Dumpty before he falls off the wall."

Dr. Kraus from the second-story offices of Preventive Concepts, Inc., soon to house a variety of new medically-related business enterprises. These range from Health Solutions, which will offer tailor-made health promotion programs for business and industry, to Call-Docs, a physician house-call service aimed particularly at the growing population of elderly.

Long-range plans for Preventive Concepts, Inc. also include the opening of a non-profit foundation "dedicated to research and development of preventive ideas and solutions, with an emphasis on electromagnetic applications to biological and human systems," according to a written description of that program.

In addition, Dr. Kraus who does regular health spots on a Columbus radio and TV station, is hoping to syndicate his radio health reports; to open a chain of Preventive Physicians Centers modeled after his own practice; and to market a variety of in-home health care products directly to consumers.

To date, says Dr. Kraus, those in preventive medicine working with individual patients (as opposed to business and industry) have not gained a very good reputation within the medical community because "our present system is almost 100% disease-focused. It's like the story of Humpty Dumpty. The present health care system is totally structured around all the king's horses and all the king's men, trying to put Humpty Dumpty back together again. We (in preventive medicine), on the other hand, are attempting to deal with Humpty Dumpty before he falls off the wall."

Those in preventive medicine also, at times, are considering everything from health-nuts to quacks because, "There's a false yet prevailing concept that real doctors deal only with the sick," Dr. Kraus says. "But the presence or absence of disease is a minor factor in the state of one's health. True health is the ability of an individual to function at his or her fullest potential — now. The present medical system impacts on less than 10% of those things that make an individual healthy."

He blames "medical school indoctrination" as one reason physicians tend to focus on sickness rather than wellness in patients. Dr. Kraus, who received his MD degree from the Ohio State University in 1973, says there were major gaps in his educational program which, at first, led him to want to practice more traditional family medicine.

"We had not one minute (of training) in nutrition, not one minute of exercise, not one minute of fitness in general," he says. In addition, there were no formal courses in "mind/body interactions," "human sexuality," or "interpersonal communications," in his program. Yet, "good communication skills are essential to the success of any practice, — not just for the benefit of the patients, but also in dealing with staff and peers."

Following a four-year stint in the Army, where Dr. Kraus taught physician's assistants and paramedics first aid and training, and two years of general practice and occupational medicine in Marion and Cincinnati, respectively, Dr. Kraus still found himself lacking in the skills he felt he needed to become successful. "I realized I was totally unprepared to deal with the political, social, economic and business realities of a practice," he says. "Instead I was trained to function in an ivory tower — in a tertiary care unit — to deal with the sickest of the sick."

Completion of a three year MBA program at Xavier University helped him become more adept at the business aspects of his profession. But he remained disturbed with medicine's "total preoccupation with disease," and he felt that "understanding, diagnosing and treating disease is a limited way to approach health care." He therefore returned to Columbus to become medical director of the Epworth Wholistic Health Center. "I have always been interested in wholism — in dealing with whole human beings. Yet the present system teaches us to deal with fragmentations of the physical. Many times this is a very ineffective way to deal with health."

Two years ago, Dr. Kraus decided to go one step further and open his

own private practice in preventive medicine; he incorporates many aspects of "wholistic health" into his programs and services. Among the individual services he offers patients is a "personal health profile" which includes an overall assessment of the patient's current health status, as well as an appraisal of future potential for disease and recommendations for enhancing health, including exercise programs and nutritional counseling.

He also provides individual patients with professional "health information," such as second opinions and reviews of patient prescriptions, and he offers patients "non-drug treatment alternatives" which are "sensibly blended with traditional therapies," according to his brochures.

Dr. Kraus also has become involved in business and industrial counseling, an area he feels holds great promise for physicians in the future. In addition to performing "executive health profiles" — which he claims are "ten times more productive than the yearly physical" because they include disease risk assessment and prospective health recommendations — he also is involved in "employee cost-sharing preventive programs," designed to meet the specific needs and objectives of the company.

His new enterprise, Health Solutions, represents an extension of that service and promises business clients even better results through seminars and programs of fitness, nutrition, stress management, substance abuse and individual responsibility for one's health. It's a program that time has arrived, he says.

"Health care as we know it today is going to change dramatically,' he says, "with an emphasis on health and prevention to blend with our previous total preoccupation with disease. There will be a tremendous emphasis on preventing problems — wellness versus illness. Major amounts of money will be going into general health promotional types of options."

The reasons for the changes are obvious, he says, and include not only economic ones but sociological and political ones, as well. "It makes sense to prevent a problem from occurring," he says. "The ultimate health care system is one that prevents 100% of all illness from ever developing to begin with. Of course this will never happen. There will always be disease. But as any good surgeon can tell you, a patient who is in relatively good health to begin with has a much better chance of recovery than one who smokes, who does not maintain a proper diet and who doesn't get regular exercise."



Dr. Kraus sits in his second-story office from which he directs his various marketing projects.

Placing the greatest demand on prevention programs are business and industry who have a vested interest in keeping health care costs down. Part of the reason for the current financial health care crisis is the way the system is structured, Dr. Kraus says. One means of changing this — and something that is already underway — is a restructuring of insurance benefits. "We will see a tremendous shift in health care insurance premium," he says. "The healthy individual will pay low premiums — the high-risk patient (smoker, drinker, etc.) will pay larger premiums."

Yet a bigger solution to the health care problem is making the patient not only more responsible for his/her share of the bill, but for his/her own health. A move back towards "a self responsible" society is the only way out of the current health care crisis, as Dr. Kraus sees it.

"We need to learn to quit blaming everyone else for our problems," he says. "Patients need to learn they are responsible for themselves. And that's a hard lesson to learn, because it's much easier to rely on a five-minute visit with the doctor who will give them a pill and somehow magically make things better."

Along with being forced to accept responsibility for their own health and well being, patients also need to be given choices, Dr. Kraus believes. And the physician of the future, he says, will not dictate treatment programs, but rather will offer the patient a variety of solutions to his/her health problems.

"In the future, the physician will be an advisory or facilitator — much like an attorney, a CPA or a stock broker," he says. "He or she will make suggestions — give the patient the information he or she needs to make a decision about his or her own

continued on page 535

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TALWIN® Nx is intended for oral use only. Severe, potentially lethal, reactions may result from misuse of TALWIN® Nx by injection either alone or in combination with other substances. (See **Drug Abuse and Dependence** section.)

Warnings: *Drug Dependence.* Can cause physical and psychological dependence. (See **Drug Abuse and Dependence**.) *Head Injury and Increased Intracranial Pressure.* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention; these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Can obscure the clinical course of patients with head injuries; in such patients, use with extreme caution and only if deemed essential. *Usage with Alcohol.* Due to potential for increased CNS depressant effects, alcohol should be used with caution. *Patients Receiving Narcotics.* Pentazocine is a mild narcotic antagonist. Withdrawal symptoms have occurred in patients previously given narcotics, including methadone. *Certain Respiratory Conditions.* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Precautions: *CNS Effect.* Use cautiously in patients prone to seizures; seizures have occurred though no cause and effect relationship has been established. Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disorientation, and confusion, which cleared spontaneously within a period of hours. Such patients should be very closely observed and vital signs checked; if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur. *Impaired Renal or Hepatic Function.* Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects; it should be administered with caution in renal or hepatic impairment. In long-term use, precautions should be taken to avoid increases in dose by the patient. *Biliary Surgery.* Some evidence suggests that unlike other narcotics pentazocine causes little or no elevation in biliary tract pressures; the clinical significance of these findings is not yet known. *Information for Patients.* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards. May cause physical and psychological dependence taken alone and may have additive CNS depressant properties in combination with alcohol or other CNS depressants. *Myocardial Infarction.* Use with caution in patients with myocardial infarction who have nausea or vomiting. *Drug Interactions. Usage with Alcohol:* See **Warnings.** *Carcinogenesis, Mutagenesis, Impairment of Fertility.* No long-term studies in animals to test for carcinogenesis have been performed. *Pregnancy Category C.* Should be given to pregnant women only if clearly needed. *Labor and Delivery.* Use with caution in women delivering premature infants. Effect on mother and fetus, duration of labor or delivery, need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown. *Nursing Mothers.* Caution should be exercised when administered to a nursing woman. *Pediatric Use.* Safety and effectiveness in children below the age of 12 years have not been established.

Adverse Reactions: *Cardiovascular:* Hypotension, tachycardia, syncope. *Respiratory:* Rarely, respiratory depression. *CNS. Acute CNS Manifestations:* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours; may recur if drug is reinstituted. *Other CNS Effects:* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor. *Gastrointestinal:* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress. *Allergic:* Edema of the face; dermatitis, including pruritus; flushed skin, including plethora. *Ophthalmic:* Visual blurring and focusing difficulty. *Hematologic:* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia. *Other:* Headache, chills, insomnia, weakness, urinary retention.

Drug Abuse and Dependence: *Controlled Substance.* TALWIN Nx is a Schedule IV controlled substance.

Dependence and withdrawal symptoms have been reported with orally administered pentazocine. Patients with a history of drug dependence should be under close supervision. Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported. In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient. Tolerance to the analgesic effect is rarely reported; there is no long-term experience with oral use of TALWIN Nx.

The amount of naloxone present (0.5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine; however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics. TALWIN Nx has a lower potential for parenteral misuse than the previous oral pentazocine formulation, but is still subject to patient misuse and abuse by the oral route.

Severe, even lethal, consequences may result from misuse of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion, ulceration and abscesses, and withdrawal symptoms in narcotic dependent individuals.

Overdosage: *Treatment:* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. For respiratory depression, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist.

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Medicine's Master Marketeer

continued

health. Medicine will be much more consumer oriented and consumer based, with an emphasis on wellness and fitness." The question the patient of the future will be asking, he says, is not "how sick am I?" but rather, "how well am I?"

Going one step further, Dr. Kraus predicts medicine will have to seek out alternative ways to deal with disease, in addition to surgery and drugs. "Science is just beginning to recognize the human organism as not just a mix of chemicals but as a mass of energy," he says. "Through electromagnetic diagnostic and therapeutic medicine, we can get extra-ordinary results with non-invasive, low risk to no risk equipment and technology," he says, adding he hopes to gain enough financial support to begin a foundation to do more research and development in this area.

Finally, he says, the physician of the future will have to be a much better communicator in order to succeed, and will continually need to market himself/herself to the changing needs of the consumer-patient. One reason Dr. Kraus has garnered a steady patient flow in a relatively short amount of time is his exposure in the media. For the past two-and-a-half years, he has acted as "health consultant" to WNCI-FM 98 radio in Columbus, giving four to 10 consumer-oriented reports on the air a week. For the past two years, he has acted in that same capacity at WTVN-TV Channel 6 in Columbus, where he gives two to three reports a week.

Calling the media an "excellent means of exposure," he says of the radio show, "I got the job by default. No one else was willing to take the time away from a practice to do it, and for the first nine months I did it without any pay."

But the job has paid off, not only in an increased patient load but in the dissemination of what Dr. Kraus feels is important consumer information. Today, with only four minutes on the air a week, Dr. Kraus's TV spots bring in more mail than any other local TV personalities' on the station, he says. "And for every letter, there are a hundred other people with questions and concerns who don't take the time to write. There's a tremendous need for more information on health. People are starved for it. In this respect, the medical profession has really dropped the ball."

While his media work has gained him a great deal of exposure and notoriety, he says, "I'm not claiming to be an authority figure who knows all the answers — I don't even know all the questions." Still, he feels many changes are inevitable, as the medical community and society at large seek new ways to deliver health care in a rapidly changing marketplace.

Medicine will be much more consumer-oriented and consumer-based. The question the patient of the future will be asking is not how sick am I, but rather, how well am I?

According to Dr. Kraus, "65% to 70% of all illness and injury episodes in this country are self-diagnosed and self-treated, without any formal contact with a health care professional. Over 50% of the people in this country have no regular physician. There's a huge untapped market out there."

Those worried about physician oversupply, he says, are not looking at the complete health care picture. "Individuals who say there's an oversupply of physicians are assuming the system is going to stay the same as it's been for the last forty years," he says. "They're wrong. Physicians in the future will be seeing smaller numbers of people, and they'll be spending more time with each patient," he says.

And a much larger percentage of that time Dr. Kraus predicts, will be spent dealing with health issues, rather than with sickness. **OSMA.**

Susan Porter is assistant editor of the Ohio State Medical Journal.

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Care of the Thermally Injured Patient

By Robert L. Gerding, MD and Jerry M. Shuck, MD

Evaluation of Thermal Injury

Thermal injury is unique in that it is currently the only quantifiable trauma. Like all other forms of major trauma, it should be evaluated in a precise systematic fashion with attention to the "ABCs." A history of the events of the burn should be sought early to provide clues to the possibility of inhalation injury or associated trauma. All too often, occult injuries are missed by the unsuspecting practitioner who is distracted by the more obvious thermal trauma. First priority must be given to maintenance of a patent airway while not overlooking the possibility of a cervical spine injury such as may occur in motor vehicle accidents, blast injuries, and in victims who may have leaped several stories to escape a fire. Adequate ventilation and general support of systemic circulation should then be carried out while in active pursuit of associated injuries. This requires a thorough physical examination for all patients with major thermal injury. Evaluation must further consider the etiologic agent, location and extent of body surface involved, estimates of burn depth, and the presence of pre-existing illnesses.

The size of the burn can easily be estimated with relative accuracy in adults by using the rule of nines, that is, 9% each for head, arms, anterior lower extremities, and posterior lower extremities, 18% each for anterior trunk and posterior trunk, and 1% for perineum. Children, however, who have relatively larger heads and smaller thighs, are better estimated by use of Lund-Browder charts which take into consideration variations in body proportion with age and are available in most emergency rooms. The palmar surface of the hand approximates 1% TBSA and is useful in estimating the size of smaller wounds.

The depth of burn wounds is frequently difficult to assess in the early phases of injury. Thermal wounds are comprised of three zones: a central zone of coagulation, a middle zone of stasis, and a surrounding zone of hyperemia. The ultimate depth of the burn wound depends largely upon the fate of the zone of stasis, where capillary sludging occurs. Changes in this area of the wound generally occur in the first 48 to 72 hours post burn. If thrombosis occurs, the wound will become proportionately deeper, whereas if microcirculation is maintained, initial estimates of burn depth will generally be accurate. The rule that "burns never become more superficial" generally applies.

One should obtain a history of the accident from any available source as well as a personal medical history of the patient.

The current trend among burn specialists is to differentiate burns in accordance with their healing potential and the need for grafting, in addition to the more traditional first, second, and third degree categories. To this end, burns may be classified as superficial partial thickness, deep partial thickness, and full thickness wounds. Superficial partial thickness burns, such as sunburns and scalds from liquids less than 170°F., generally will heal within two to three weeks without functional impairment or hypertrophic scarring. They are characteristically pink, moist and supple, have intact hair shafts, demonstrate rapid capillary refill and are exquisitely painful. Blisters, if present, have relatively thick walls and frequently increase in size of the early post burn period. Skin grafting will not decrease healing time nor improve the final cosmetic appearance of the wound and is therefore not indicated.

At the other extreme, full thickness burns are characteristically dry and leathery with marked lack of sensation and absent capillary refill. If blisters are present, they are thin walled and do not increase in size. Unless very small, all burns in this category will ultimately require skin grafting. Attention is therefore directed toward the optimal timing of wound closure. Early excision and primary skin grafting should be performed in the first three to five days post burn if possible.

Deep partial thickness burns compromise the intermediate category of wounds. They characteristically have a more reticulated red and white surface which is relatively dry and less pliable than surrounding skin. Hair shafts frequently can be removed with ease. Pain is diminished due to cutaneous neuropraxia but pressure sensation is clearly intact. Burns in this category are "indeterminate" in depth and healing potential; as such they frequently present the most challenging management problems. Healing time is distinctly variable, depending upon the natural progression of wound depth in the

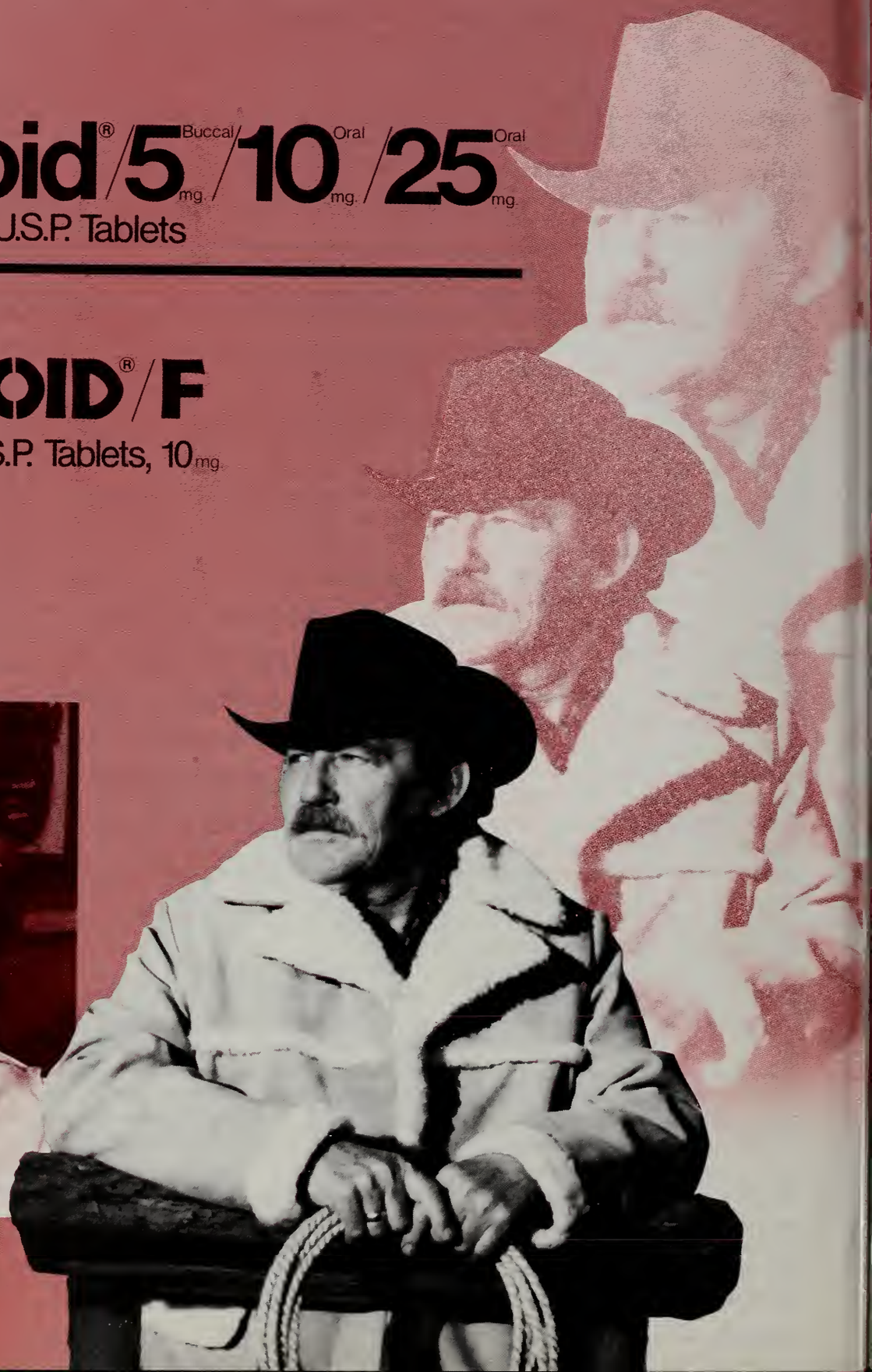
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first two days post burn. Other important criteria are the special characteristics of the involved skin, the presence or absence of infection, and the general medical condition of the patient. Healing sometimes occurs in less than three weeks but frequently exceeds four to six weeks. Furthermore, those permitted to heal without grafting may develop hypertrophic scars, contractures, and functional impairment. For these reasons, those burns judged to require more than three weeks to heal are deemed candidates for early burn excision and primary skin grafting.

Triage of Burn Victims

Very simply stated, all major and critical thermal injuries should be referred to a specialized burn center to take full advantage of their expertise and highly developed ancillary support systems. These include adults with partial thickness burns of more than 20% to 30% TBSA (total body surface area), children with similar injuries of more than 15% TBSA, all patients with full thickness burns involving more than 10% TBSA and any burns in patients under the age of 2 years and over the age of 60 years. In addition, any major burns with involvement of the hands, face, feet, or perineum should be transferred to a "burn unit." Electrical injuries, chemical injuries, inhalation injuries, and burns occurring in association with underlying significant illness or other major trauma are also generally managed best in a specialized burn care facility.

Patients with minor burns not involving the hands, face, feet, or perineum can usually be managed effectively through the outpatient department. For example, partial thickness burns of less than 10% TBSA in children and less than 15% TBSA in adults frequently do not require admission to the hospital. This is also true of full thickness burns involving less than 2% TBSA. Should skin grafting be advised, it can generally be performed either as an outpatient procedure or by pre-arranged admission on the elective operating room schedule. Electrical burns of greater than 110 volts, chemical injuries, inhalation injuries and frostbite are virtually never managed as outpatients.

Patients who fall in neither of the above categories require hospital admission but generally do not require care in a specialized unit. If possible, however, they should be referred to a general hospital having a qualified surgeon and staff familiar with the basic principles of burn care.

The current trend among burn specialists is to differentiate burns in accordance with their healing potential and the need for grafting, in addition to the more traditional first, second, and third degree categories.

Initial Management and Preparation for Transport

Once it is determined that a patient with major thermal injury should be transferred to a burn unit or other facility, certain measures must be taken to insure safe and timely transport. First, a patent airway must be insured and 40% humidified oxygen should be routinely administered. If inhalation injury is suspected on clinical or historical grounds, the patient should receive 100% oxygen by mask rebreather and early endotracheal intubation must be considered. Tracheostomy is rarely, if ever, indicated and has been shown to increase burn mortality from respiratory complications.

As mentioned earlier, one should obtain a history of the accident from any available source as well as a personal medical history of the patient. A thorough physical examination is mandatory to rule out associated injuries, and determine the size and depth of the burn wound. All burned clothing should be removed and the patient covered with clean or sterile sheets. The routine applicaton of cold towels is ill-advised and may lead to hypothermia which will hamper efforts at resuscitation.

Once the "ABCs" have been completed, establish at least one large-bore peripheral intravenous line (preferably through unburned skin) and administer lactated Ringer's solution without dextrose to maintain a urine output of about 30 to 50 ml urine per hour for adults, or 1 ml per kilogram per hour for children. The Parkland formula is probably the most widely accepted guideline for fluid resuscitation of major thermal injury and is the one used at our institution. By this formula, the 24 hour fluid requirement will approximate 4 ml per kilogram per percent (non-first-degree burn). One half of the calculated amount is given in the first 8 hours post injury. The remainder is apportioned over the following 16 hours. It is important to realize that such formulas serve only as guidelines and that resuscitation must be tailored to the needs of the individual. Infants and small children will generally require the addition of maintenance fluids to the calculated fluid requirement. Furthermore, estimates may be grossly in error in patients with high voltage electrical injuries and very deep or fourth degree burns. In these patients the urine should be examined for the presence of hemochromogens. If present, planned urine output should be doubled, that is, 75 to 100 ml per hour in adults and 2 ml per kilogram per hour in children to reduce the risk of renal damage. This is done by first increasing the rate of intravenous infusion and secondly by the judicious use of mannitol and urine alkalinizing agents. All patients requiring fluid resuscitation should have a foley catheter inserted for hourly urine measurement. They typically have

generalized ileus and should also have an nasogastric tube to suction prior to transport.

Intravenous morphine is preferred for pain control either in small bolus injections or as a drip. Narcotics should never be given by the intramuscular route. Tetanous prophylaxis is indicated as per guidelines for other tetanus-prone wounds. Hyperimmune tetanus globulin is not routinely required. Systemic antibiotics are not usually given unless indicated for the management of associated injuries. One notable exception is high voltage electrical burns for which prophylactic penicillin may be indicated to reduce the risk of anaerobic infection in necrotic muscle. Do not attempt to debride the burn wound or apply topical antibacterial agents. This is generally unnecessary and will hamper evaluation by the receiving institution.

Three categories of burns deserve further mention. Circumferential burn injuries require frequent peripheral vascular checks to insure adequate circulation within the confines of a relatively non-elastic burn wound. The loss of a peripheral pulse in the face of adequate cardiovascular support indicates the immediate need for medial and lateral escharotomies. Fasciotomies, though rarely required, may be necessary for high voltage electrical burns and for very deep burns involving muscle. Chest escharotomies are sometimes necessary to relieve restrictive ventilatory compromise.

Electrical burns are commonly associated with ECG changes including cardiac arrhythmias. Such patients must be monitored continuously before and during transport with aggressive management of arrhythmias should they arise. Chemical burns require immediate attention and should be diluted with copious amounts of water which is preferred to other specific neutralizing agents. Further management of the chemical burn is best directed through communication with the receiving institution. With these exceptions, the burn itself requires very little attention prior to transfer. Temporary wraps with dry sterile dressings are all that are required during transport.

Transport of any trauma victim is best accomplished early, but not before evaluation is complete and resuscitation is well under way. Attention to the ABC's of trauma, adequate fluid resuscitation, close monitoring and detailed communication with the receiving hospital are the key ingredients to safe transport of the burn victim. **OSMA**

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References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

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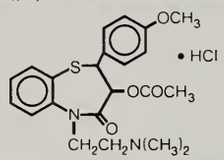
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CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given: a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

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Obituaries

STANLEY J. BIRKBECK, MD, Vermilion; St. Louis University School of Medicine, 1927; age 84; died April 18, 1984; member OSMA and AMA.

JACK R. COHEN, MD, Steubenville; Ohio State University College of Medicine, 1934; age 76; died April 18, 1984; member OSMA and AMA.

LARREY B. GALE, MD., Newport; Jefferson Medical College of Thomas Jefferson University, Philadelphia, 1948; age 59; died March 20, 1984; member OSMA and AMA.

EDWIN M. GOYETTE, MD, San Antonio, Texas; University of Vermont College of Medicine, Burlington, Vermont, 1932; age 76; died March 1, 1984; member OSMA and AMA.

FRED ELLIS HALL, MD, Bellaire Bluff, Florida; Ohio State University College of Medicine, 1917; age 89; died March 24, 1984; member OSMA and AMA.

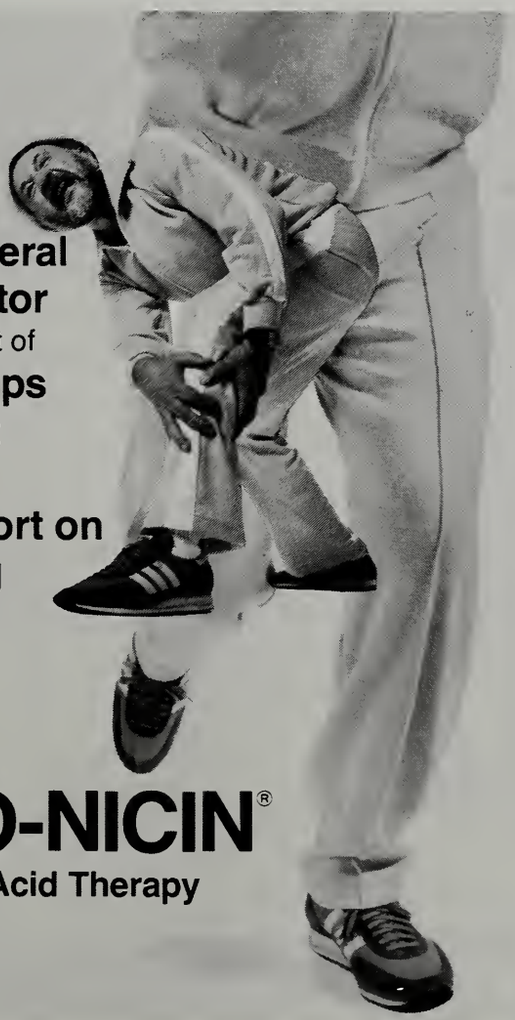
WILLIAM MARCUS, MD, Louisville, Kentucky; Case Western Reserve University School of Medicine, 1915; age 94; died April 27, 1984; member OSMA and AMA.

ALBERT J. MICHELS, MD, Cleveland; University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania, 1946; age 61; died April 11, 1984; member OSMA and AMA.

MARTIN REINER, MD, Toledo; OIrvosi Fakultas Tudomanyegetem, Debrecen, Hungary, 1938; age 74; died May 6, 1984; member OSMA and AMA.

JOHN H. RENTSCHLER, MD, Ashtabula; Jefferson Medical College of Thomas Jefferson University, Philadelphia, 1942; age 67; died April 13, 1984; member OSMA and AMA.

ROBERT O. TUREK, MD, Franklin, North Carolina; Case Western Reserve University School of Medicine, 1940; age 68; died April 12, 1984; member OSMA and AMA.



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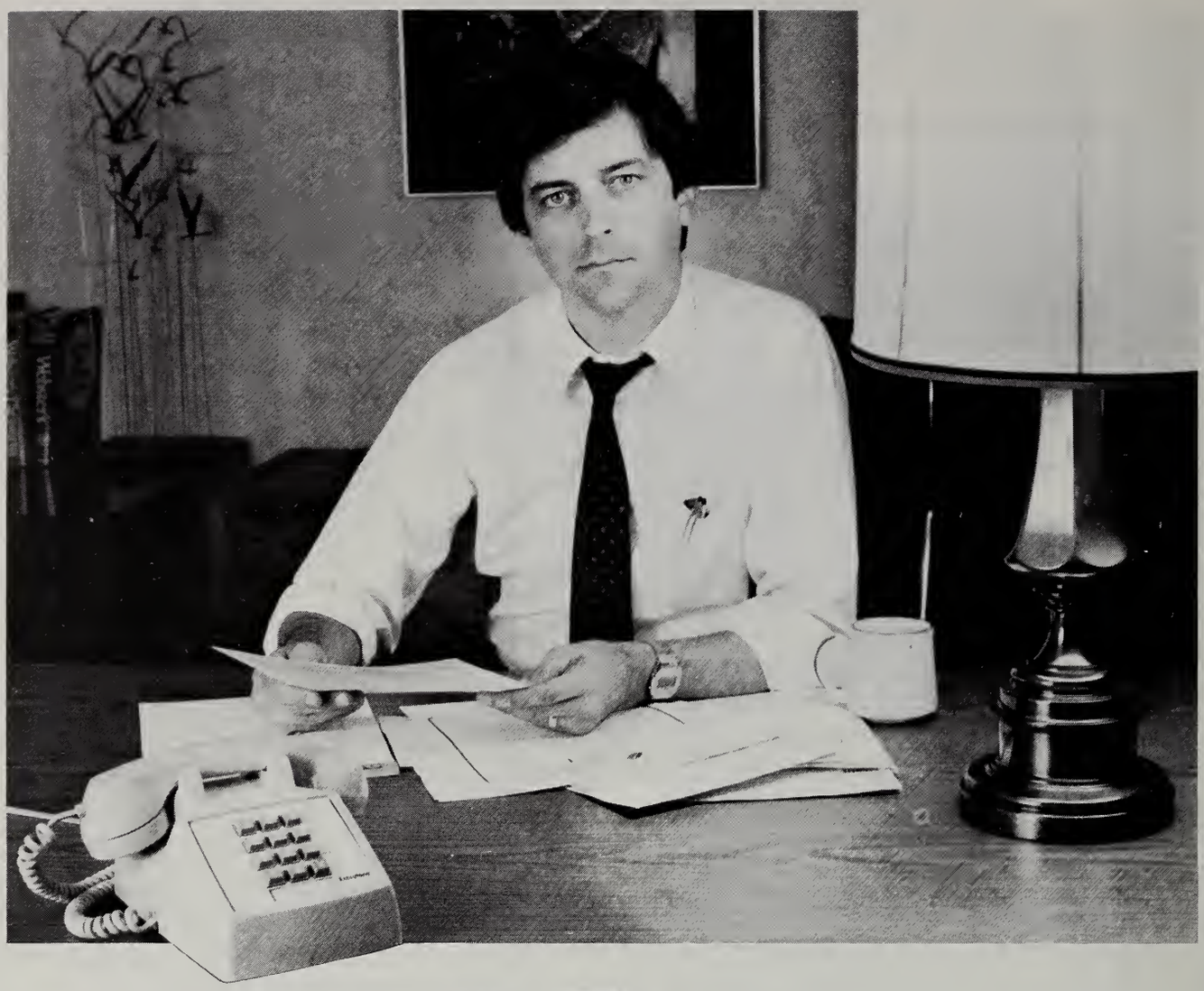
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Continuing Education

July

CHEMONUCLEOLYSIS: July 14; Stouffer's Inn on the Square, Cleveland; sponsor: The Cleveland Clinic Foundation; cosponsor: Smith Laboratories, Inc.; 8 credit hours; fee: $200, no fee to residents; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

SECOND ANNUAL SYMPOSIUM ON MEDICAL PROBLEMS OF MUSICIANS: July 26-30; Paepcke Auditorium, The Aspen Institute, 1000 N. Third St., Aspen, Colorado; sponsor: The Cleveland Clinic Foundation; cosponsor: Music Associates of Aspen, Inc.; 17 credit hours: fee: $250; contact: Center for CME, Cleveland Clinic Educational Foundation; 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio: 1-800-762-8172; Outside Ohio: 1-800-762-8173.

August

ALLERGY UPDATE FOR THE PRACTICING PHYSICIAN: August 10-12; The Resort Inn, Kings Island, Cincinnati; sponsor: Division of Allergy/Immunology, Children's Hospital Medical Center, Cincinnati; cosponsor: American Academy of Allergy & Immunology; 9 credit hours; fee: $135, $70 for residents; contact: Division of Allergy/Immunology, Children's Hospital, Elland & Bethesda, Cincinnati 45229, phone: 513/559-4326.

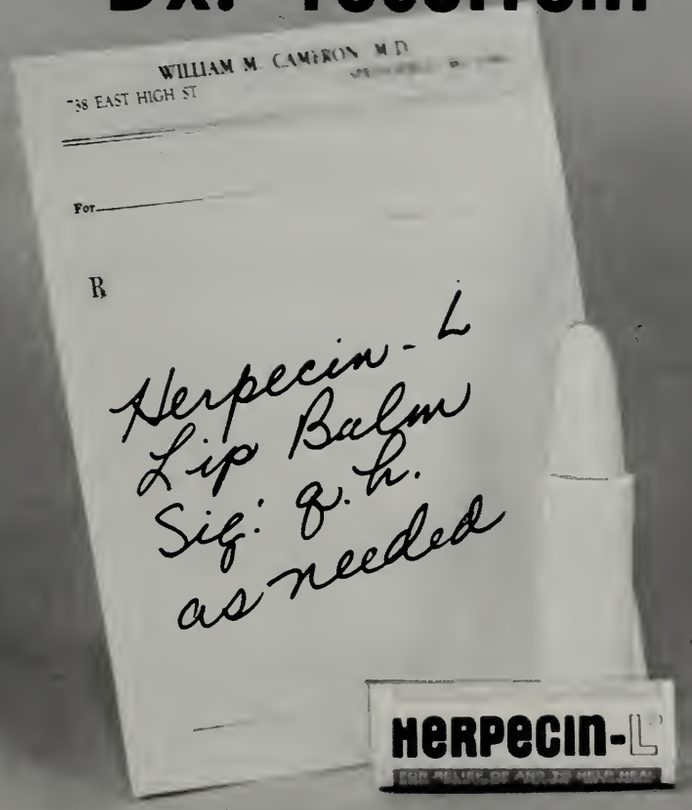
IMPORTANT ISSUES AND DEVELOPMENTS IN OBSTETRICS AND GYNECOLOGY: August 10-12; Kings Island Inn; sponsor: Department of Obstetrics and Gynecology, University of Cincinnati; 17 credit hours; fee: $350, $250 for residents; contact: Stanley J. Stys, M.D., University of Cincinnati, M.L. #526, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-4277.

REGIONAL ANESTHESIA: ANATOMY AND TECHNIQUES: August 18, 19; Gordon H. Scott Hall, Wayne State University, Detroit, MI.; sponsor: Wayne State University School of Medicine; 12 credit hours; fee: $275; contact: Wayne State University School of Medicine, Division of CME, 4H DRHUHC, 4201 St. Antoine, Detroit 48201, phone: 313/577-1585 or 577-1110.

September

UPDATE IN PULMONARY DISEASE: September 5-7; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 15 credit hours; fee: $180, $120 for physicians-in-training; contact: Center for CME, The Cleveland Clinic Educational Foundation; 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio: 1-800-762-8172; Outside Ohio: 1-800-762-8173.

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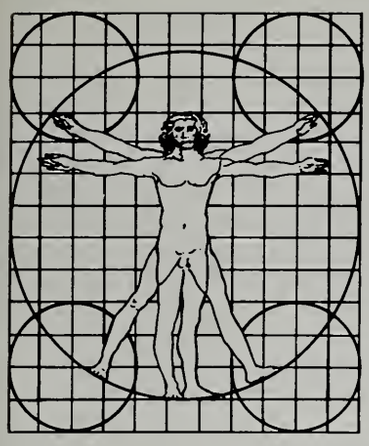
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CLINICAL & SCIENTIFIC

TAPWATER LEAD IN HOMES OF CHILDREN WITH UNDUE BODY LEAD BURDEN

A. Harold Lubin, MD
Steven A. Signs, MS, C(ASCP)
Albert Caffo, PhD

Lead concentrations in household tapwater were analyzed in 49 homes of children with known elevations of blood lead (⩾ 30ug) in Columbus, Ohio, to assess the contribution of household tapwater intake to body lead burden. Average lead concentration for all water samples tested was 4ug Pb/1; below the U.S. E.P.A. maximum allowable 50ug Pb/1 standard. Levels of lead in blood and water showed no correlation nor significant difference in lead concentrations for water supplies in homes with lead compared to copper service pipes. Consistently low levels of lead in Columbus water (< 10ug/1) probably are the result of the alkaline pH (10.0) reducing the solubility of lead in water. Water in Boston, Massachusetts, has a more acid pH (6.5), resulting in a greater incidence of water lead concentrations > 50ug/1. Based on an estimated "steady state normal intake" in a preschool child of approximately 30ug lead/day from all sources, lead intake from tapwater is unlikely to increase significantly a child's total body burden of lead in cities complying with E.P.A. drinking water standards.

Introduction

Environmental contribution to undue body lead burden has been of major concern for a number of years. Lead in the environment originates from multiple sources, including automobile and industrial exhausts, paint, and construction materials (e.g. plumbing).[1,2] In the home, aside from air, paint, and dust, tapwater may be another contributing source of excessive lead in the body.[3,4] Leaching of lead to high proportions from water service lines and household plumbing has been reported, and lead in home tapwater has been shown to contribute to body lead burden in adults and children.[5,6,7,8]

Physiological factors of an increased intestinal absorption, more rapid respiratory rate, and more frequent hand to mouth activity predispose infants and children to increased intake of lead from the same routes of accumulation in adults and create greater risks of lead toxicity.[9,10,11] Levels of lead in blood associated with toxic symptoms have been reduced progressively since the mid-1950s. Recently, levels of whole blood lead in children with an adult range (30-40 ug%) usually considered to be normal have been correlated with decreased mental capabilities, learning disorders, and hyperactivity.[12,13,14] It is of value, therefore, to define the potential contribution of undue body lead from each of multiple sources. In the following study, lead concentrations in household tapwater from homes of children with known elevated blood lead levels were analyzed to assess the contribution of household tapwater on body lead burden.

Materials and methods

Two hundred thirty household tapwater samples were collected from 49 homes of children (ages 6-18 months) with blood lead levels ⩾ 30ug/dl (mean 39, SD 6).[15] These children were identified through the screening of a Columbus, Ohio, inner-city pediatric population. Heparinized whole blood was diluted 1:30 with 0.1% Brij 35 solution (General Biochemicals, Chagrin Falls, Ohio) and lead was determined using an IL Model 251 Atomic Absorption Spectrophotometer with an IL Model 355 Tantalum Boat Flameless Atomizer attachment. Water samples collected in lead-free, polyethylene bottles were acidified immediately to pH 2 with concentrated nitric acid (1N), and lead was measured using the same AAS unit described above. A detection of 1×10^{-11}g Pb was attained. Quality control was provided for blood and water using Center for Disease Control (CDC) proficiency testing and U.S. E.P.A. specimens, respectively. First morning cold tapwater samples collected in the children's homes represented water standing in the household plumbing overnight and estimated the relative plumbo-solvency of pipes in the homes. A morning five-minute "flush sample" (collected after allowing water to run for five minutes) was obtained to analyze the lead contribution of community conduits. Midday and evening samples typify water consumed through the course of the day. Data on community water service (i.e. pH, hardness, and pipe composition) was supplied by the Columbus City Water Department.

Results

Figure I illustrates the relationship between whole blood lead levels in children and water concentrations in the homes where they reside. No significant correlation can be drawn between the two parameters. Sixty-seven percent of the children resided in homes with ⩽ 4ug/1 lead in tapwater and all of the children lived in homes with mean tapwater lead levels ⩽ 10ug/1. Table I contains the results of analyses performed on tapwater obtained throughout the course of the day. The mean concentration for

From the Ohio State University, Department of Pediatrics, and the Nutrition/Trace Metals Division
Columbus Children's Hospital
Submitted March 21, 1983

the morning five-minute "flush" collection varies significantly ($p < .001$) from the morning, midday, and evening samples for which mean lead values show no significant variations. The mean lead levels in tapwater served by public service lines of different composition (lead and copper) is presented in Table 2. No significant difference can be demonstrated between the two compositions.

TABLE 1
LEAD IN HOUSEHOLD TAPWATER* (COLUMBUS, OHIO)

TIME OF SAMPLE	$\bar{X}$ ± S.D. LEAD (UG/L)
First morning	4.2 ± 6.5
Morning with 5 minute flush	0.5 ± 0.8**
Midday	4.0 ± 4.1
Evening	5.1 ± 6.2

*Combined bathroom and kitchen cold tapwater lead concentrations in homes of children with undue body lead burden.
**Lead concentration of the 5 minute morning flush is significantly lower ($p \leq .001$) than water allowed to come into prolonged contact with home plumbing. No significant variation can be demonstrated between the morning, midday and evening samples.

TABLE 2
COMPARISON OF LEAD LEVELS IN HOUSEHOLD TAPWATER OF HOMES WITH SERVICE PIPES OF DIFFERENT COMPOSITION* (COLUMBUS, OHIO)

SERVICE COMPOSITION	$\bar{X}$ ± S.D. LEAD (UG/L)**
Lead	4.2 ± 4.5
Copper	4.2 ± 4.6

*Data represents the collective means of morning, 5 minute flush, midday and evening samples.
**No significant difference can be demonstrated between the two compositions.

Discussion

Using the parameters which contribute to the usual lead intake in children, illustrated in Figure 2, and assuming the usual daily intake of approximately 1 liter of household water per child, the mean lead intake from Columbus tapwater would range from 1-20ug/day.[16] Provided a usual daily lead intake of 100-250 ug, a water intake of 1-20ug/day would be a small percentage of the total. The mean water lead concentrations in the homes of children with undue body lead burden appear to contribute minimally to their burden. Finally, data collected relating whole blood lead levels in children and water lead concentrations in homes in which they live suggest that blood lead levels in children do not correlate with increasing tapwater concentrations of lead, when all levels are $\leq$ 10ug/1. While the lead content of most ground water and surface waters have ranged from 1-10ug/1 and only $< 0.5\%$ of samples in one survey exceed the current U.S. standard of 50ug/1, important geographic differences do exist which reflect variability in water quality.[17,18,19,20] In those communities where water lead levels consistently exceed the Environmental Protection Agency standard of 50ug/1, it is possible that water lead as a significant source of undue body lead burden still must be considered.

Factors increasing the corrosive action of water include "softness," acidic pH, and increased temperature.[13,19] When such corrosive water is distributed through lead pipes, elevated levels of lead in water may reach the tap.[5,21] Also, the use of lead soldering alloy to join copper pipes has been found to contribute to the level of lead present in water.[1,3]

In the case of tapwater from Columbus, Ohio, the effect of a relatively high pH and hardness of water indicate unfavorable conditions for the solubilization of available lead and could lead one to expect that the amount of lead solubilized is minimal. These findings are substantiated by the low levels of lead found in Columbus tapwater. (Table 3) Solubility experiments indicate an approximate lead solubility of $<$ 10ug/1 at pH's above 8.0.[19] The effect of lower pH's ($\leq$ 6.5) increasing plumbo-solvency has been well documented.[19,22] In our study, the lack of significant variation between the morning and midday catch indicates that water standing in household pipes overnight does not accumulate beyond what appears to be a maximal equilibrium solubility for lead in water of Columbus's characteristics. This can be demonstrated further by the finding that the early morning five-minute "flush" sample is far lower than the midday catch. Water enters the household pipes from the service pipes at a level of 0.50ug/1 and reaches a level of 4.0ug/1 within a relatively short period of time. As a result the morning, midday, and evening samples indicate very similar levels, and water lead attains a solubility limit (4ug/1) that is far below the maximum allowable concentration (50ug/1) in drinking water mandated by the Environmental Protection Agency.

Pickup of lead from water systems has been illustrated by other investigators with the presence of higher lead concentrations in a standing sample compared with a running sample used as evidence of lead pickup.[5,6,22] In these studies, the lead content of drinking water has been higher at the tap than at the treatment plant. Highest concentrations have been found at early morning samples and lowest in running samples.

Usually those studies which have shown that lead in drinking water is an important source of lead exposure have represented regions in which the water is predominantly soft, "aggressive" water.[7,21,22] One study of lead in water in the Boston, Massachusetts area demonstrated an average tapwater pH range of 6-7, a hardness of 14mg/1 (Table 3) and resulted in mean tapwater lead concentrations of 30ug/1 (n=337) with a range of 13-1,510ug/1; 15% of all homes analyzed exceeded government standards (Table 3A).[16] Studies in Scotland, Belgium, and Wales have demonstrated similar correlations with soft water.[8,23,24] This data indicates that Columbus, Ohio, water is inherently low in lead and its organo-complexes and not particularly corrosive toward any lead compounds which it may contact.

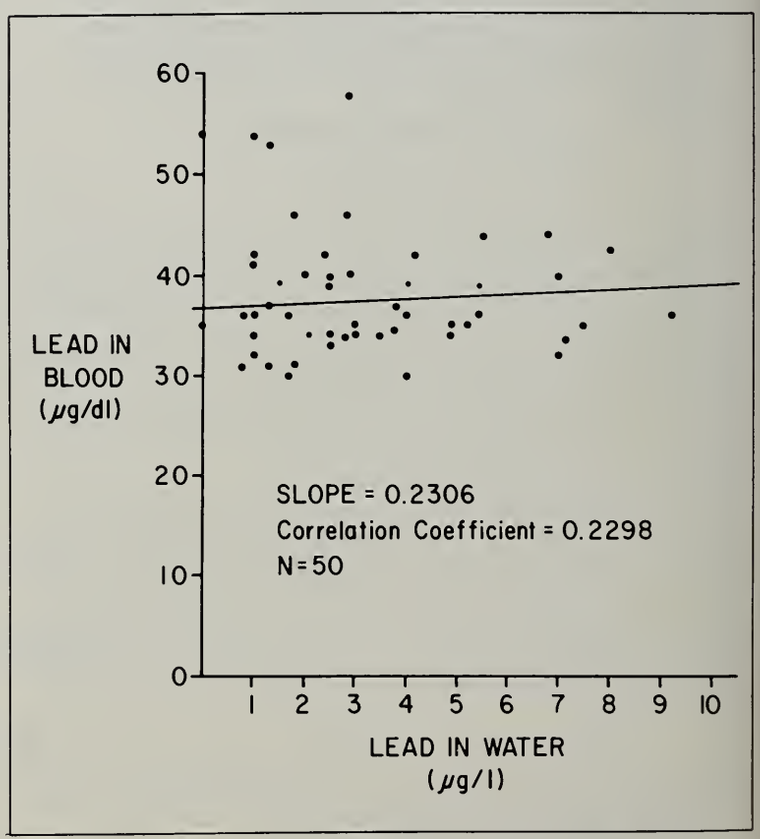


FIGURE 1

TABLE 3
WATER CHARACTERISTICS IN TWO AMERICAN CITIES

CITY	pH	HARDNESS (MG/L)	T.D.S.* (MG/L)	LEAD (UG/L)
Columbus, Ohio	9.6	101	187	10
Boston, Mass.	6.5	14	30	13

*Total dissolved solids

TABLE 3A
HOUSEHOLD TAPWATER LEAD LEVELS IN TWO AMERICAN CITIES

CITY	(UG/L)	(UG/L)	% HOUSEHOLDS VIOLATING EPA STANDARD
Columbus, Ohio (N=230)	4	0-10	0
Boston, Mass. (N=337)	30	13-1510	15

Data presented supports previous findings relating water quality (pH, relative hardness, temperature) and piping situations to plumbo-solvency. The characteristics of the tapwater in Columbus, Ohio, do not enhance corrosion of lead compounds or the excessive accumulation of lead or its complexes in solution, nor does Columbus water on the basis of endogenous lead contamination or as a result of its interaction with transport structures contribute significantly to the lead body burden in the population of children we studied.

Since water treatment methods vary widely, one approach to facilitate a decrease in potential hazards of undue body lead burden from water would be to encourage a more uniform acceptance of alkaline pH and high level of hardness throughout the United States. Alternatively, a less easily enforced approach to spot-test lead in water levels in homes with preschool children in cities which do not meet Environmental Protection Agency minimum accepted standards might be necessary.

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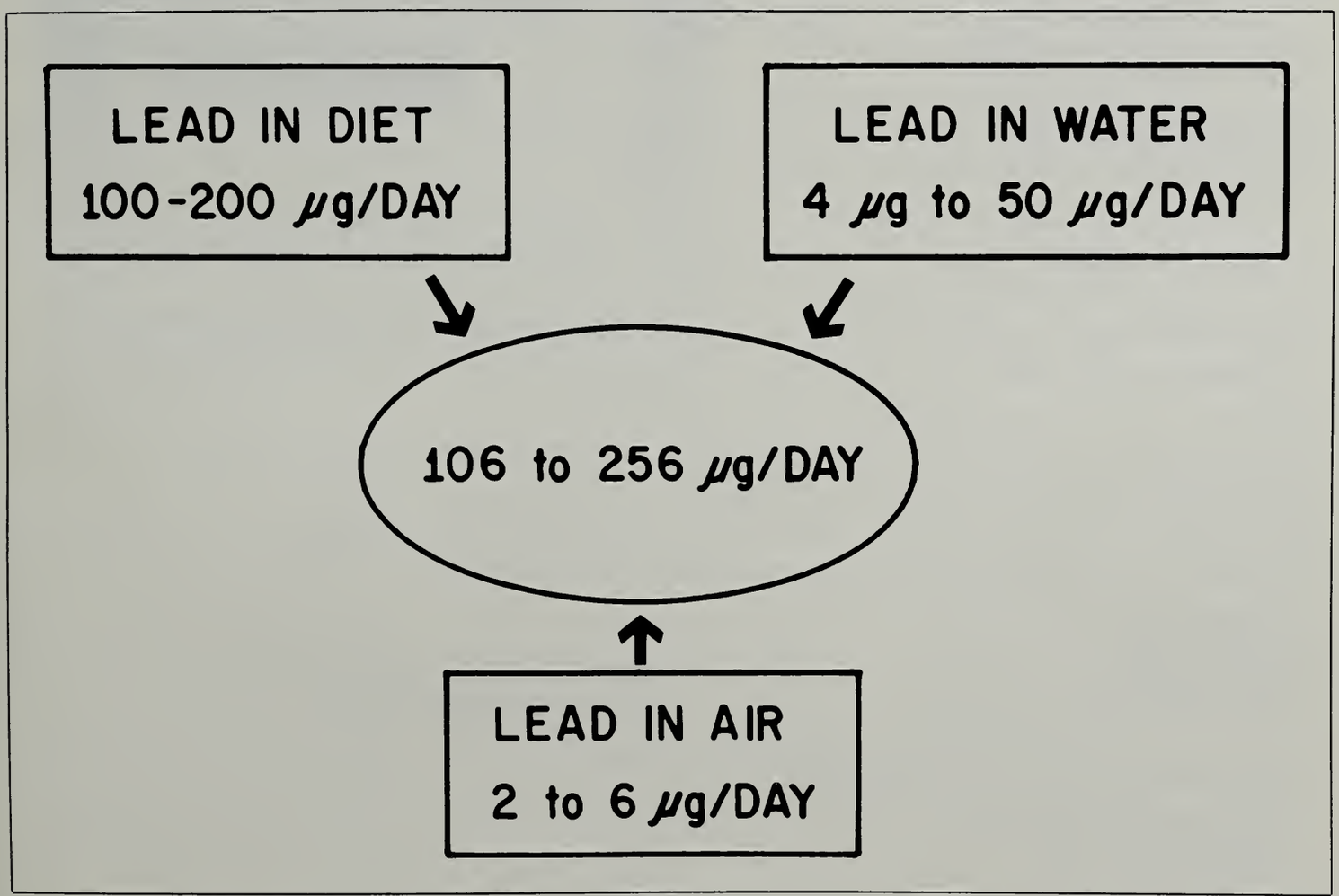


FIGURE 2

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Patient Education Needed

Breast Self-Exams Ignored

A woman's doctor is most likely to be her best source of information on breast-self-examination, according to a recent survey conducted by the Gallup Organization for the American Institute for Cancer Research.

Yet most American women continue to ignore the importance of breast self-exams for early detection of breast cancer, even though they believe it has value in controlling breast cancer, the survey shows.

While 88% of women agree there is a lot of value in early detection of breast cancer and 81% report they have practiced breast self-examination at least once, nearly two-thirds or 63% of American women do not perform monthly breast self-exams. Only 30% report they have practiced a breast self-exam at least once a month during the past year.

Among the most common reasons given for failure to do so are, "I see a doctor frequently and the doctor does it," or "My doctor never told me I should." According to the survey, 77% of the women who have practiced breast self-examination in the last year learned about it from their doctors.

In addition, the survey noted that age plays a part in women's attitudes toward breast self-examination. Women under 29 and over 50 are almost twice as likely as women 30-49 to have never practiced breast self-exams. Older women were more likely to respond, "I think only a doctor should do it" or "I'm not that concerned about breast cancer," even though the risk of developing breast cancer increases with age.

The American Institute for Cancer Research recently launched a public education campaign to encourage and remind women to perform regular breast self-examinations.

Physicians or individuals wishing more information may write to BSE Campaign, c/o the American Institute for Cancer Research, Washington, DC 20069.

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Colleagues In The News

Newly elected officers of the Providence Hospital in Cincinnati are: president, **LARRY BEST, MD;** vice-president, **JOHN KRIEG, MD;** secretary-treasurer, **JOHN ZERHUSEN, MD.**

BRIAN K. BRADFORD, MD, Toledo, has been appointed to the Governor's Council for the Ohio Chapter of the American College of Physicians.

STEPHEN HENRY DIMLICH, MD, Kettering, has been named chief of staff at Miami Valley Hospital. He is an associate clinical professor, section of surgery, Wright State University School of Medicine.

JAMES P. FARMER, MD, Austinburg and **WILLARD J. HOWLAND, MD,** Canton, recently received the Distinguished Service Award from the Ohio State Radiological Society at its Annual Meeting in May. The award is given in recognition for service and achievement in the specialty of Radiology.



Ray W. Gifford, Jr., MD

Cleveland Physician Honored by Mayor

RAY W. GIFFORD, JR., MD, Cleveland, recently received the "Mayor's Award for Volunteerism." Dr. Gifford, along with staff and community leaders, helped to develop a program to provide physicians' care for the unemployed.

Medical staff officers for Toledo Hospital are as follows: **JOHN B. GIBBS, MD,** re-elected chief of staff; **FRED V. GIPSON, MD,** vice chief of staff; **GREGOR K. EMMERT, MD,** re-elected secretary-treasurer. Members-at-large include **PHILIP L. KUEBBELER, MD,** four-year term; **RALPH C. WHALEN, MD,** one-year term; **GEORGE M. PIPOLY, MD,** one-year term; and **WILLIAM K. FACEY, MD,** one-year term.

LEON GOLDMAN, MD, Cincinnati, received the 1983 Clark W. Finnerud Award in recognition of his many accomplishments, including writing six books, international recognition as a pioneer in laser medicine, and his many contributions of scientific and clinical data since 1933. The award is given by the Dermatology Foundation.

LUTHER W. HIGH, MD, Millersburg, recently received the Alumni Achievement Award from Capital University in Columbus. The award is based on exceptional contributions to society, profession and church.

WALTER W. JONES, MD, Columbus, was elected to the board of directors of the National Society to Prevent Blindness (Ohio Affiliate) at its annual meeting recently held in Columbus.

WILLIAM S. KISER, MD, Cleveland, Chairman, Board of Governors, Cleveland Clinic Foundation, was elected president of the American College of Physicians Executives at its ninth national conference in May. The American College of Physician Executives is a national professional association exclusively for physicians who specialize in medical management.

HENRY G. KRUEGER, MD, was installed as president and chairman of the board at the Cleveland Academy of Medicine's annual meeting in May. Serving with Dr. Krueger this year, 1984-85, are: president-elect, **HERMANN MENGES, JR., MD;** vice-president, **DANIEL A. DEUTSCHMAN, MD:** and secretary-treasurer, **WILMA F. BERGFELD, MD.**

CHESTER LULENSKI, MD, general surgeon at St. Alexis Hospital, has been named "Clinician of the Year" by the Cleveland Academy of Medicine.

WILLIAM T. PAUL, MD, was installed as president of the Academy of Medicine of Columbus and Franklin County during ceremonies at the Medical Society's annual dinner. Dr. Paul is director of the Mt. Carmel Hospital Family Practice Program. **OWEN E. JOHNSON, MD,** Columbus, was elected secretary-treasurer.

1984 officers at Our Lady of Mercy Hospital in Cincinnati are: medical staff chief, **WALTER RUGH, MD:** vice-president, **J. HARRY STAGAMAN, MD;** secretary-treasurer, **LLOYD OWENS, MD;** and members-at-large, **G. FRANKLIN LOWE, MD** and **FRANK CLEMENT, MD.**

O. DAVID SOLOMON, MD, Cleveland, was recently installed as president of Phi Delta Epsilon, an international medical fraternity. Dr. Solomon is assistant professor of ophthalmology at the Case Western Reserve School of Medicine.

LEON SPEROFF, MD, Cleveland was featured in an article in *Good Housekeeping Magazine.* The article was entitled "The Best 120 Doctors in America." Dr. Speroff is medical director of the obstetrics and gynecology department at MacDonald House and chairman of reproductive biology at Case Western Reserve University.

RAYMOND SUSKIND, MD, received the 1984 Award for Outstanding International Health Service and Education from the Cincinnati Chapter of Project Hope. Dr. Suskind directs the Institute of Environmental Health at the University of Cincinnati Medical Center and UCX's Kettering Laboratory.

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Please see summary of product information on the following page.

References: 1. Data on file. Hoffmann-La Roche Inc., Nutley, NJ. 2. Wormser GP, Keusch GT, Heel RC: *Drugs 24*:459-518, Dec 1982. 3. Ronald AR: *Clin Ther 3*:176-189, 1980. 4. Rubin RH, Swartz MN: *N Engl J Med 303*:426-432, Aug 21, 1980. 5. Cunha BA: *Postgrad Med 70*(6):149-156, Dec 1981. 6. Neu HC: *Infectious Diseases 10*(6):4, 19, Jun 1980. 7. Jones SR: *Ration Drug Ther 13*(11): 1-5, Nov 1979.

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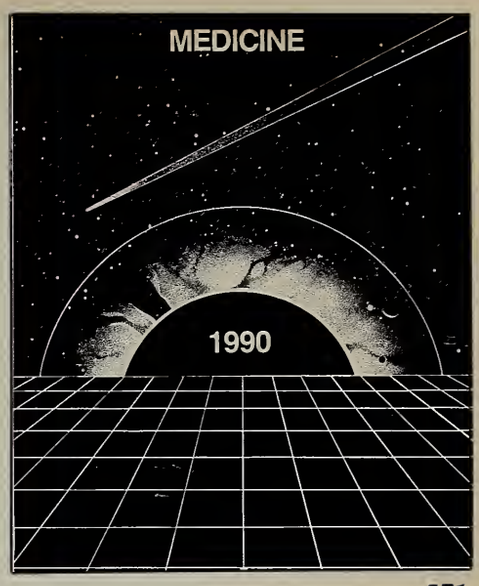
1983 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

THE Ohio STATE Medical Journal
(ISSN 0030-1124)



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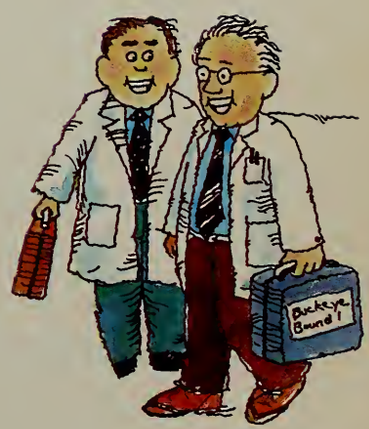
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Does Ohio Have Too Many Doctors?

More than four years ago, the Graduate Medical Education National Advisory Committee (GMENAC) shocked the medical community with its prediction that there would be an oversupply of physicians by 1990.

Last year, a report on physician manpower in Ohio, released by the Ohio Board of Regents, brought the matter home: "A careful analysis of physician needs for the State of Ohio, using traditional parameters, strongly indicates the potential of a sizeable overproduction of physicians by the early 1990s. Further, a sizeable number of foreign and out-of-state physicians being licensed to practice in Ohio will add to that surplus."

Yet, the Board of Regents report was hesitant to put the brakes on Ohio's seven medical schools until further study could be completed — especially in view of the fact that there are still underserved areas in the state, as well as a public perception of a physician shortage due to long waits for a doctor's appointment and long waits in doctors' offices.

And, of course, the report has its opponents — people who feel that a physician surplus is just so much bunk. In an article that ran in the March '81 *Journal* ("The Road to GMENAC," *OSM Journal*, March, 1981), James E. Morgan, MD, claimed that a physician surplus, predicted in the 1930s, led to a moratorium on medical schools, which, in turn, led to a rush to increase physicians which resulted in the present, so-called "physician surplus": "Thus, between 1936 and 1980, there has been a complete turn of the wheel . . . If the past is any indication of the future, more careful consideration should be given before the number of students starting medical school is limited. Otherwise, a 44-year-old cycle may begin all over again."

The report's proponents, however, are just as loud. In an article which ran last year in the *New England Journal of Medicine* ("Is the Establishment Defensible?", *NEJ*, October 27, 1983), California physician Robert G. Petersdorf, MD, wrote: "To sum up the manpower picture, we have too many doctors, particularly specialists, and we need to institute birth control. We need to quit training our own competition, because it is eating us alive . . ."

This issue of the *Journal* takes a look at the physician manpower situation in Ohio. It seems the closer we get to 1990, the more vocal the proponents and opponents of the GMENAC theory become. We've included views of both sides in this issue, as well as an updated report from the man who started it all, Alvin Tarlov, MD, who chaired GMENAC at the time it issued its prediction. And, to add some local interest, we've included an interview with Columbus physician William Millhon, MD, who served on a GMENAC sub-committee.

We've also examined the problem of a physician *shortage* in Ohio, providing a look at those areas in the state where a shortage of physicians exist, as well as a view of physician specialties — which are the most popular in the state?

Does Ohio have too many doctors . . . or not enough? You'll have to decide that for yourself. It's an issue, however, that needs to be examined and re-examined until a consensus is reached . . . or until 1990 actually arrives. And, at this point, it's difficult to predict which will come first.—
Karen S. Edwards

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Letters to the Editor

Couples' Therapy Applauded

To the Editor:

I appreciated your little note, with regard to marital therapy for physicians (News, OSM Journal, June, 1984). I agree that the physicians' narcissistic image has been the main roadblock for the treatment of many problems that physicians, as any other professional, face in marital life. This "self destructive behavior" has been present in many of my encounters during my ten years of experience in the treatment of couples (particularly when sexual dysfunctions are present), and especially now that the role of "doctor's wife" has been changed to "doctor's husband." This situation has required changes in the approach of therapy. I find myself trying to state from the beginning that a patient is a patient regardless of his/her profession, with a problem that should be taken care of. We have made such tremendous progress in treating the impaired physician — and yet treating this problem is just as necessary, and should be just as acceptable.

I agree one-hundred percent that the only way to do this is in joint sessions with both members of the couple present. It is also extremely important that the basic principle of confidentiality be observed, since we are dealing with colleagues, whom we meet socially in other parts of our lives.

I believe that this is an area that needs to be expanded in the future, to make it easier for our colleagues to come forward, and share their problems so that we can deal with them.

Sincerely,
Enrique N. Kaufman, MD
Cincinnati, Ohio

WANT TO EXPRESS AN OPINION?

(**The OSMA Journal** *welcomes letters from its readers. Please address all letters to: Executive Editor, 600 S. High St., Columbus, Ohio 43215. Letters may be edited to meet space requirements.*)

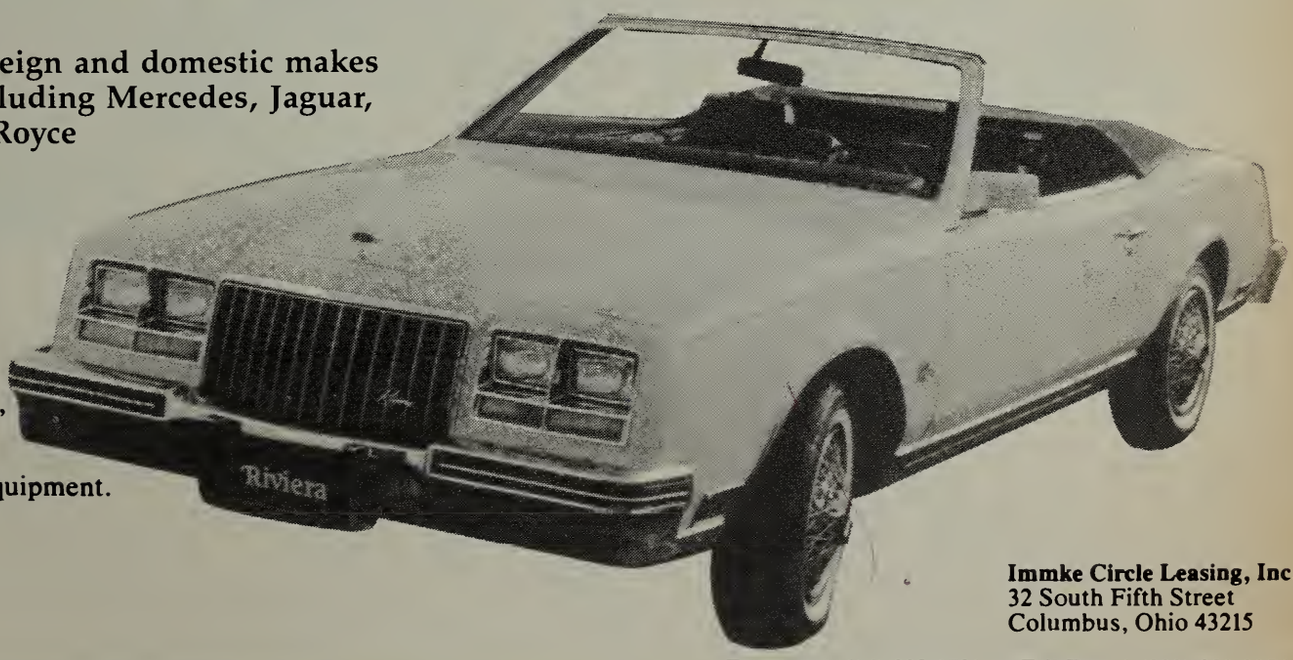
Correction

Michael J. Felter, MD, was listed in our New Member list in June as being from Columbus. Dr. Felter lives and practices in Sandusky.

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Yes, There Are Too Many Doctors . . . But Should We Take a Stand?

By A. Robert Davies, MD

There is a broad consensus that the medical manpower shortage of the 1960s is a thing of the past. While there are still areas of the state which are underserved, the number of physicians now practicing in Ohio is probably adequate. A frequently used ratio of physician to population-at-large is 1:2500. The current ratio in Ohio is approximately 1:1800.[1]The number of primary care physicians in practice has increased from 4,073 in 1970 to 6,108 in 1983. During the same period of time the population of the state has grown only 103,000 from 10,688,000 to 10,791,000. It would seem that we are approaching physician oversupply in the state of Ohio. The response of the medical schools and the state legislature to the needs of the 1960s has been effective.

Physician oversupply is projected on the national scene as well.[2,3] Should organized medicine in general and the OSMA in particular take a stand on the issue of physician surplus? I recommend that we do not. This is a problem in which many segments of our society have a stake and the solutions to the problem must be found through broad public debate and political concensus. The OSMA must be ready to assist in a variety of ways as this public debate and political consensus is sought, but we should not develop OSMA policy which in any way proposes to limit medical school enrollment or state licensure as a solution to this dilemma.

An OSMA policy setting limits on medical manpower as set forth above could only be seen as self-serving. Even though we could justify such a policy on the basis of tax dollar savings; even though we could justify such a policy on the basis of health care cost control; even though we could justify such a policy on the basis of the declining applicant pool and quality preserving issues, we must not do so. We would be seen as practicing professional birth control in order to preserve a seller's market and protect the doctor's income!

The cost of physician education is enormous. It is estimated that the price tag for a four year medical education in the USA is approximately $160,000. In Ohio in 1983 the taxpayers picked up 53% of the annual cost per student in direct subsidies, that is $22,750 per student. As we will have in excess of $91,000 invested in each Ohio medical and osteopathic school graduate, we have an obligation as informed citizens to ask our legislators to be sure that our tax dollars are being used wisely. Perhaps "capitation," $22,750 per student, is not the way to fund medical schools. I expect that if the deans of our schools were given a similar amount of money with which to operate their school they could do it very well without having to rely on a certain number of students in each class to qualify for state subsidy.

The OSMA must be ready to assist in a variety of ways, but we should not develop an OSMA policy to limit medical school enrollment or state licensure.

The deans of our schools are doing a very good job insuring quality education for the future physicians of our state. This job has been made ever so much more difficult in the last several years because of decreases in federal support for education and research, and because of the general inflationary trends in the economy. The solution to the proposed physician oversupply problem must take this into account. We must strive to help the deans continue to provide high quality educational experiences. We must be careful that we don't make their particular fiscal problems worse than they already are.

Another piece of the medical manpower over supply puzzle is the number of U.S. citizens studying medicine in the so called "off shore schools" in the Caribbean. While U.S. medical schools in fifty states graduate approximately 16,000 students a year there are probably another 20,000 students in the Caribbean schools who intend to return to their home country (USA) when they finish their four years in school! We have very little understanding of the quality of the medical education these students receive. Many of the students can pass the appropriate licensing exam but the rigorous clinical experience our Ohio students receive in the teaching hospitals in the state is difficult to measure relative to the clinical experiences to which the Caribbean educated students are exposed. This poses both an educational issue as well as a licensure issue. How many tax dollars should we spend untangling this piece in order to be fair to the

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students who have invested time and money in their Caribbean medical education as well as to the citizens of Ohio who trust their medical board to insure that the doctors licensed here are capable and competent to attend to their medical needs?

The OSMA should help locate physicians in underserved areas or conceive of programs to help meet medical needs in those areas.

We must begin the deliberations soon. It takes seven to nine years to educate a medical doctor from entry to completion of residency. Any change made in class size will not be noticed until 1991 except for the small change in availability of residents in the teaching hospitals. The OSMA should be available to testify and to help explain the intricate nature of the issues. The OSMA should help locate physicians in underserved areas or conceive of programs to help meet medical needs in those areas. The OSMA should not take sides by developing policy which restricts entry into or graduation from the high quality medical and osteopathic schools in Ohio. **OSMA**

A. Robert Davies, MD, is a family practitioner in Troy, Ohio, and a member of the Ohio Public Health Council. He is also a member of the OSMA Committee on Communications.

References

1. Report on Physician Manpower in Ohio: Requirements, Supply and Cost. The Ohio Board of Regents. July 15, 1983.
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OSMA Welcomes New Councilors

By Karen S. Edwards

William J. Marshall, MD



William J. Marshall, MD, received his medical degree from the University of Maryland in 1958, graduating magna cum laude, then interned at Philadelphia General Hospital in Philadelphia, Pennsylvania. Following his internship, he came to Ohio, where he took his residency at Cincinnati General Hospital.

Dr. Marshall currently practices internal medicine in Dayton, Ohio, and serves as the Director of both the Cardiac Rehabilitation In-Patient and Non-Invasive Cardiac Laboratory at the Kettering Medical Center in Kettering, Ohio. He also serves as associate professor of medicine at Wright State School of Medicine in Dayton.

A past President of the Ohio Society of Internal Medicine, as well as a past president of the Montgomery County Medical Society, Dr. Marshall is active in numerous other professional associations, including the American College of Cardiology, the American College of Physicians, the American Medical Association, and the Ohio State Medical Association (of which Dr. Marshall is a 20-year member).

Dr. Marshall will be replacing Herman I. Abromowitz, MD, as Second District Councilor for the following counties: Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble and Shelby.

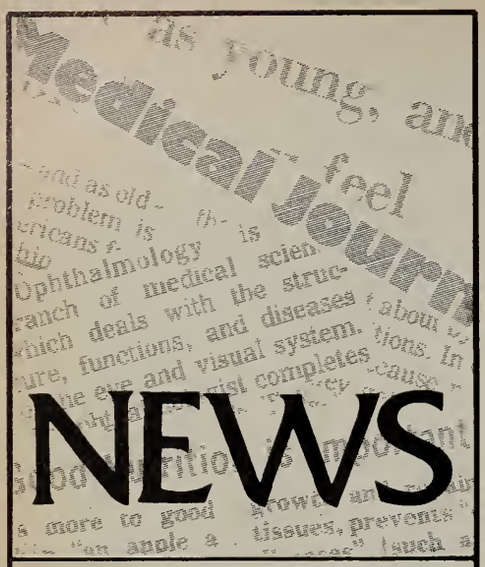
Nermin Lavapies, MD



A native of Istanbul, Turkey, Nermin Lavapies, MD, received her medical degree from the University of Istanbul Medical School in 1956, then served a rotating internship at Wheeling Hospital, Wheeling, West Virginia. She took a general practice residency at the Ohio Valley General Hospital in Wheeling and currently shares a family practice in Martins Ferry, Ohio, with her husband, Felipe Lavapies, MD, who is also an OSMA member.

Dr. Lavapies is very active in organized medicine and is currently serving as secretary-treasurer of the Belmont County Medical Society, a position she has held since 1981. In 1980, she served as the society's president. She is also active in the Ohio Association of Family Practice (OAFP), where she has served as Continuing Education Program Director; Seventh District Director; and as a member of the Minority Affairs and Family Practice Care Standards Committee. In addition, Dr. Lavapies is involved in numerous medical positions in Martins Ferry, including: consultant of the Cancer Screening Clinic; member of the Board of Health; and director of the Drug and Alcohol Detoxification Unit at Martins Ferry Hospital, where she also serves as medical director.

Dr. Lavapies will replace H. Judson Reamy, MD, as Seventh District Councilor for the following counties: Belmont, Carroll, Coshocton, Harrison, Jefferson, Monroe and Tuscarawas. **OSMA**



a compilation of the latest developments, reports and products of interest to physicians.

edited by Susan Porter

New method tested for transfusing oxygen

A new method for transfusing oxygen to patients who refuse blood transfusion, per-fluorocarbon infusion, has been used successfully by researchers at the University of California at Irvine, according to a recent report in the *Archives of Surgery*.

The procedure was tested on six severely anemic surgical patients who had refused to receive blood products for religious reasons, but agreed to participate in a multicenter, prospective randomized trial conducted by the Alpha Therapeutic Corporation.

Although arterial oxygen content did not increase appreciably after PFC infusion, oxygen consumption increased dramatically, according to the researchers' report. Because PFCs carry oxygen by direct solubility, they result in nearly complete unloading of oxygen at tissue oxygen tensions, the researchers point out.

A second benefit associated with PFC infusion relates to micro-circulation, they add. The small particle size of PFCs "may allow the PFC to flow through constricted capillary beds and may improve plasma flow through these vessels as well."

The researchers note, however, some adverse reactions to the method, including lowered blood pressure in one patient, an abnormal liver function test in another, and transient diseases of white blood cell counts following infusion in five of the patients.

Springfield, Alliance physicians capture golf tournament honors

Jerry K. Shell, MD, a Springfield ophthalmologist, captured low gross honors in the 1984 Ohio State Medical Golfers Association Tournament held early this summer, with a score of 76. His name will be inscribed on the W.D. Inglis Cup.

George M. Wilcoxon, MD of Alliance, competing in the Age 70 and over bracket, took low net honors with a score of 67. Dr. Wilcoxon's name will be inscribed on the Dr. Ray Stephens Memorial Trophy.

This marked the first year for the Dr. Carm Shamess Memorial Awards for Most Improved Golfers. **Howard A. Keiser, MD**, a urologist from Lorain, shaved 24 strokes from his 1983 score to earn first place in the gross competition. A tie resulted between **George E. Huston, MD** of Marietta and **Dr. Shell** for net honors. Each reduced his net total by eight strokes from 1983.

Nurse midwife deliveries up in 4-year period

The number of babies delivered by nurse midwives more than doubled between 1975 and 1979, according to a new report from the National Center for Health Statistics titled *Midwife and Out of Hospital Deliveries United States, 1978-79*. Since the number of out-of-hospital deliveries remained relatively constant, the figures reveal the increasing interest in home births and in hospital births attended by midwives, the publication says.

Information for the study was obtained from entries on live birth certificates filed in the US in 1978 and 1979. Data was compiled both on nurse midwives, registered nurses who have obtained additional education in delivery and the lay or "granny" midwife who typically serves low economic or rural areas.

The report indicates that three types of women deliver in nonhospital settings: those who cannot afford a hospital confinement, those who desire a more natural family-centered birth experience, and those who intended to give birth in the hospital but go into labor and deliver accidentally at home.



Foreign-born mothers are more likely than mothers born in the US to be attended by midwives, the report says; 30% of the nurse-midwife deliveries are to black mothers.

The report indicates a reversal of the trend towards hospital deliveries which were at 55.8% in 1949, then rose dramatically until 1970 when 99.4% of all births occurred in a hospital setting.



Dementia overlooked by young physicians

As many as one-fifth of all cases of senile dementia may be overlooked by young doctors, while that same number of cases may be improperly diagnosed as senile dementia, says a recent report in the *Archives of Internal Medicine.*

The study looked at the diagnoses of 380 patients by the 57 medical school residents at Johns Hopkins Memorial Hospital. It further indicated that inaccuracies tended to be influenced by the patients' age and educational levels. Dementia sometimes was overlooked in patients under 65 years of age.

Because some cases of dementia can be treated, recognition of the disease is critical if successful therapy is to be implemented, the study concludes.

Cocaine use on the rise

Patients seeking symptomatic relief from medical problems such as nasal bleeding, chronic hoarseness, headaches, depression and anxiety may be suffering from the use of cocaine, says a recent article in *Medical World News.*

Use of the illicit drug is on the rise, particularly among middle income individuals; the average user today is white and 30 years of age, many have college degrees and nearly half earn more than $25,000 a year, the article says. It is estimated that some 4 million to 5 million people now use the drug regularly, while 22 million Americans have tried the drug at least once.

Physicians are advised to check for cocaine use by recognizing the above symptoms, and then taking urine samples.

In addition to early diagnosis — which the article lists as "the single most effective effort a physician can make to aid a patient using cocaine" — doctors are advised to refer the patient to a substance abuse specialist on an inpatient or outpatient basis, depending on the severity of the case.

Physicians should practice what they preach, . . . and preach what they practice

Physicians who practice good health habits, themselves, are much more likely to prescribe sound health practices for their patients, a study completed recently by two Ohio State University medical students shows. On the other hand, doctors who neglect their own health probably will fail to detect poor health habits in their patients.

The researchers, who were interested in finding out why doctors don't practice more preventive medicine, surveyed 270 family physicians in the state, since past studies have indicated that the public relies heavily on primary care physicians for information about health.

Areas studied included weight, exercise, use of seat belts, tobacco and alcohol.

Doctors who exercise are 50% more likely to encourage their patients to exercise, the study shows. Nearly 70% of those doctors who smoke discuss the topic with their patients, while 80% of the non-smokers bring it up. Nearly all doctors considering themselves light to moderate drinkers advise patients against alcohol abuse, while only 70% of those considering themselves "heavy" drinkers discuss alcohol with their patients.

The use of seat belts was the only exception. While nearly all doctors surveyed said they used seat belts, only one-third discussed them with their patients; most did not consider it a health issue.

Beepers available for kidney patients

Patients waiting for kidney transplants in the Ohio State University Hospitals Transplant program may now take advantage of pagers. Fifty battery operated long-range pagers have been donated to the program by the Miami Valley Radiotelephone AERO ALERT.

The pagers are being distributed to those patients on the active cadaveric kidney waiting list who live within the area covered by AERO ALERT. Previously, these patients had to be near a telephone at all times.

Doctors wishing more information on the pagers may call the OSU Transplant Program at 421-8746.

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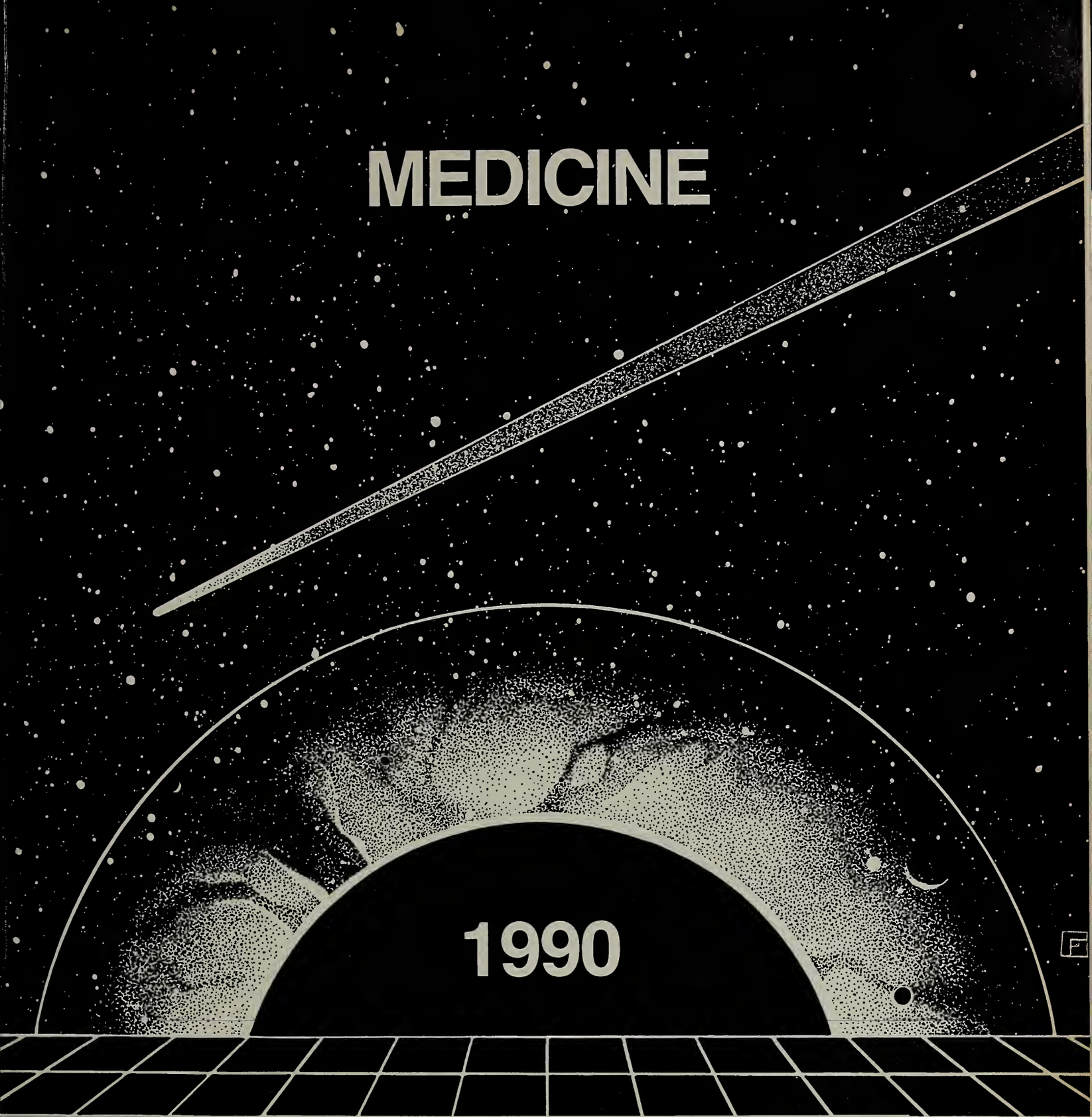
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By Karen S. Edwards

You may not recognize the practice of medicine in another decade or so.

"Medicine in 1990 is going to be much more formalized and highly structured than it has been in the past," says Alvin R. Tarlov, MD, who spoke at the Richard L. Fulton Memorial Lecture held in Columbus last year.

"A convergence of two forces — the increasing supply of physicians, and attempts by society to contain the cost of health care — is bringing about a fundamental transformation of the health-care system."

The prediction is much like the one Dr. Tarlov made four years ago as Chairman of the Graduate Medical Education National Advisory Committee (GMENAC). At that time, he and his colleagues predicted an oversupply of physicians by 1990.

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"During the 1960s and 1970s, there was a general consensus that more physicians were needed — and the medical profession was in the forefront of that consensus. As a result, new medical schools were built with state appropriations, and by 1972, medical school enrollment had increased 21.9%.

"The growth of physician supply is not slowing down, either," says Dr. Tarlov. "In the next twenty or thirty years, the number of students entering the medical profession will be at the rate of the '80s (in 1982, 142 schools graduated 18,248 medical students), while attrition will continue at the rate of the '60s."

This, according to Dr. Tarlov, will continue until 2010, when growth will, eventually slacken . . . but leaving a surplus of 70,000 physicians in its wake.

"By 1990, we will have 215 physicians per every 100,000 people in the U.S. By 2000, that number will increase to 240 physicians. Yet, 170 physicians per 100,000 population is considered about right."

Dr. Tarlov is most concerned with the oversupply in the specialties.

"The only areas where shortages may exist are in physical, emergency and preventive medicine, and in both child and general psychiatry. Osteopathic general practice and general internal medicine will strike a near balance." Almost everything else, says Dr. Tarlov, will experience a surplus.

And it is this surplus which, Dr. Tarlov says, is already responsible for changes in our health-delivery system.

"Contractual medicine couldn't have happened without the rising number of physicians," he says.

"Health services are now assuming the same corporate-like organization and structure as industry, and a mature industry at that," he adds, pointing out that one-third of all the hospitals in the country are in a multi-hospital system.

"By 1990, 22% of all hospitals will be for-profit, and non-profit hospitals may own restaurants, hotels and other for-profit businesses to escape cost control reimbursement," Dr. Tarlov says.

All of this leads to the question of how will the social responsibility of these institutions — as well as the medical profession — be changed?

"Third-party payers have already put a distance between the physician and the patient," Dr. Tarlov says, and competition is creating further problems.

"With the increasing supply of physicians, competition for patients is high. Corporations are taking advantage of this, using the aggregate number of their employee-patients to obtain purchasing power."

As far as the medical profession is concerned, however, competition has already created some subtle differences.

"The physician will become much less powerful in the new medical care system, while the power of corporate employers will increase. In fact, most physicians will be practicing in some kind of corporate structure."

"Residents are looking with increasing favor on salaried positions. The young physician today is willing to sacrifice a potentially large income for an assured salary, a quick start-up, and protection from the competition," Dr. Tarlov says.

That's why the enrollment in HMOs has grown (and continues to grow) so steadily, and why it will continue to grow.

And that's what portends the type of structured medical environment Dr. Tarlov envisions.

"The physician will become much less powerful in the new medical care system, while the power of corporate employers will increase. In fact, most physicians will be practicing in some kind of corporate structure."

Regulation, attempting to contain health care costs, will dispose of unnecessary tests, and patients will have a direct say in the types of cost restraints used.

"Patients, as well as physicians, will be given incentives to restrain costs," Dr. Tarlov says.

He also envisions a change in physicians' practice habits.

"Where physicians used to decide what tests to order, and whether or not to hospitalize a patient, corporations will begin to make those kinds of decisions. They will approve hospital admissions, allowable lengths of stay, which specialists to use, etc. The participation of individual physicians will be gradually reduced."

The patient, too, will be playing an increasing role in his or her health care.

"The patient will choose his or her physician, and health care plans. They will be aware of their benefits, and will control the physician's use of hospitalization, medicine, etc." . . . which makes the physician of the future responsible to not only government, but also the hospital and patient underwriter.

"The patient won't be a patient in the traditional sense anymore. He or she will be a client of the corporation."

By 1995, Dr. Tarlov believes "60% of physicians will be involved in some health care plan, and 40% will be under pressure to join a health care plan."

"Changes *will* occur. *Should* they occur is not the question anymore."

What recommendations would Dr. Tarlov make to avoid, or at least reduce, the strain that seems imminent on the traditional doctor-patient relationship?

"The growth of physician supply should be restrained. Entrance to medical schools should be reduced; U.S. citizens should be prevented from entering medical schools in Mexico and the Caribbean; foreign medical graduates should be discouraged from entering practice here in the U.S.; and

a health manpower policy should be established."

Still, lessening the strain on the traditional practice of medicine is not going to abolish it. Because of increasing physician supply and the public struggle to contain costs, medical social changes are even now altering the profession.

"Our profession derives its power from the value society assigns to it. Right now, ours is an elitist profession because society places a high value on our work."

He ticks off those elements which have given the profession its high regard.

"It controls admission to itself; has exclusivity of services; is self-regulatory; and has altruistic purposes," he says.

But professions are in a continuous state of evolution, and the medical profession is no more stagnant than any other profession.

"We have evolved into higher and higher levels of specialization — and with specialization comes advanced levels of bureaucracy."

The profession, he claims, now lacks flexibility.

"The profession no longer has complete control over admission to itself. Twenty percent of the nation's physicians are alien graduates of foreign medical schools, outside of the accreditation program. Now, in addition, 2,500 Americans are returning yearly from substandard medical schools in the Caribbean and in Mexico to train and practice in the United States.

"The profession has lost substantial autonomy in rulemaking to legislative and regulatory bodies. Regarding exclusivity of services, as much as 25% of medical services which were formerly provided exclusively by physicians will be delivered by nurse practitioners, physician assistants, nurse midwives, optometrists, podiatrists, psychologists and others.

"Altruism is the principal or practice of unselfish dedication to the welfare of others. Do we behave altruistically, however, when we oppose Medicare and Medicaid legislation? When we reject assignment for the care of the elderly? When we allow large

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Medicine 1990

"It Won't Be As Bad As You Think"



According to Columbus internist William A. Millhon, MD, reading the 1979 report of the Graduate Medical Education National Advisory Committee (GMENAC) — which predicted a physician surplus by 1990 — is a bit like reading George Orwell's book *1984* in 1974. One can't help but wonder if the future is really going to be as ominous as it's depicted.

"Yes, I think there is going to be a surplus of physicians, but I don't think it's going to create the problems that Dr. Tarlov is predicting," Dr. Millhon says.

Dr. Millhon was one of a number of specialists who studied the physician oversupply problem as a member of one of GMENAC's sub-committees. As a Trustee of the American Society of Internal Medicine, and President of the Ohio Society of Internal Medicine at the time, Dr. Millhon had the necessary qualifications. But he was less than charmed by the experience.

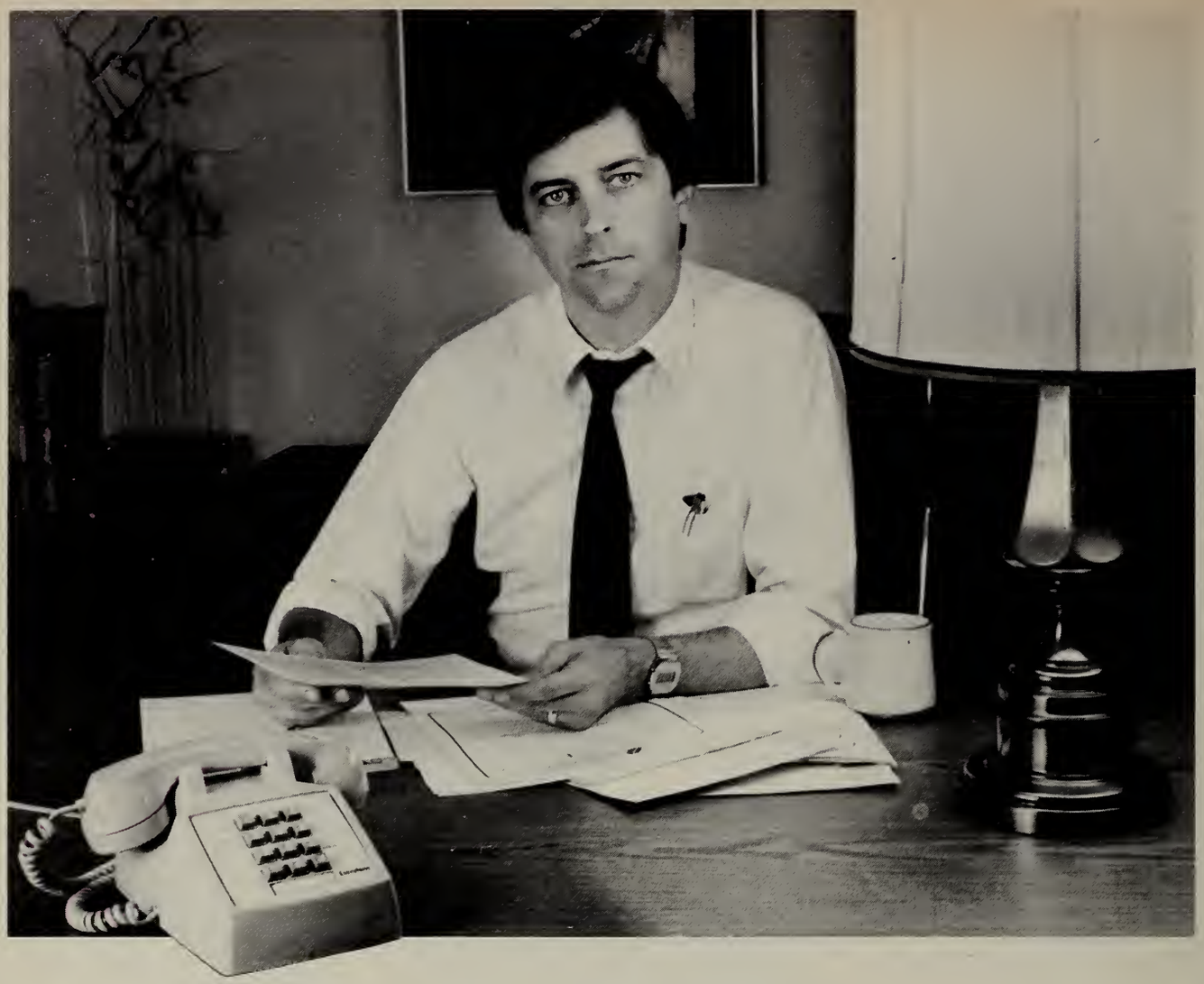
"We were using the Delphi technique, which is not a very reliable method," he says. "We based our study on 'what would happen if the status quo remained unchanged?' We didn't factor any future events or possibilities into our figures at all."

And that's what leads Dr. Millhon to state that the 1990 predicted by GMENAC will be about as threatening as 1984 proved to be.

"For one thing, we never factored in the element that today's medical student wants an 8 a.m. to 5 p.m. job. And, too, there is the fact that more and more women are entering the profession. I don't mean to sound chauvinistic, but most of the women entering practice are only working part-time. Of course, what all this means is that we're going to *need* more doctors to see patients. That's going to take up some of the surplus which GMENAC predicted."

Other factors need to be considered, too, Dr. Millhon insists. "We never said 'what would war do?' We never asked 'what if they developed a new surgical technique for this?' Nor did we take into consideration the rapidly increasing number of elderly. There are so many elements that need to be taken under consideration in any discussion of the future — and yet, we didn't. We weren't allowed. It was a typical government project," he says.

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segments of our fellow men to remain outside the medical care system? Do we place hazardous stress on our altruistic ideals when we assume ownership of diagnostic and treatment centers and take profits from tests and procedures performed by others on our patients? Are altruistic ideals not susceptible to perversion by conflicts of interest? With industrialization of the system, and emphasis on efficiency, productivity, cost effectiveness, and defined hours, will the altruistic ideal of the profession be compromised, and will the course of the doctor-patient relationship be diminished?

"The profession is not disintegrating, but a redefinition is needed," Dr. Tarlov claims.

The social responsibility of the medical profession needs to be reviewed and made applicable to these times.

"Prior to the 20th century, the major objective of the medical profession was to prevent death from disease. During the 20th century, we corrected physical abnormalities in the patient by medication and surgery. Now, the biological status and risk factors are being determined. Quality of life is being assessed.

"With industrialization of the system . . . will the altruistic ideals of the profession be compromised, and will the course of the doctor-patient relationship be diminished?"

"The medical profession is changing its focus from technology to promoting the highest level of physical, mental and social functionality."

And with the new focus comes a

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It won't be as bad

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The new pressures to contain costs, exerted on the profession by government and industry, will also eat into GMENAC's surplus, Dr. Millhon believes.

"Every new doctor on the street increases health care costs," he says, explaining that recent figures show each individual physician controls $400,000 worth of health care.

"The government is not going to stand for that much longer. Something will be done."

Something is likely to happen, too, as far as the specialties are concerned.

"With the DRGs and prospective payment system, we're going to see more hospitals close — and with the hospitals go the training grounds for residents. They're not going to have any place to go to train in their specialty."

Many specialties have already voluntarily trimmed the size of their training programs, based on the premise of oversupply.

"But if we cut down on the specialties, then we are going to have to increase the number of family physicians," Dr. Millhon says. "You can't win."

What steps does he see Ohio taking in order to reduce whatever surplus problems remain?

"Eventually, the state will turn to the medical schools," he says — then argues that, logically, that may be the best place to start.

"Once you've graduated these young people — once they've worked for four years to get where they want to be, how can you say to them 'you can't go into this specialty?' No, if you're going to limit opportunities in medicine, you should do it at the medical school level."

Dr. Millhon is inclined to believe Ohio has too many medical schools.

"We really didn't need all the schools that have been built, but it's something of a political matter. Legislators felt they needed a medical school in their part of the state, and they argued that, by having the school in their area, they could take care of the physician shortages that existed there. But, of course, that's a fallacy. The students get better job offers and they move on. The shortages in those areas still exist, despite the schools."

"You can't be dogmatic about it. You can't really say how bad it's going to be. There is just no way to predict 1990 medicine in 1975."

He's reluctant to come out and say, however, that medical school enrollment should be reduced.

"You see, if you mention limiting enrollment, the profession is looked on as being self-serving."

Yet "training the competition" is not the point, he insists.

"Medicine is not selling socks. I'm not concerned that there are going to be more doctors to compete with. There are too many other factors that enter into the practice of medicine to worry about training the competition."

But he says that medicine will be different for his younger counterparts — perhaps because of the oversupply.

Despite the fact that the AMA's medical student section recently came out against mandatory assignment, Dr. Millhon thinks it is something they had better get used to . . . "because by the time they are out in practice, they're going to *have* to take assignments."

And not just because they've been regulated to do so, he says. An oversupply problem is going to crop up eventually — whatever its proportion — and today's students are going to find patients at a premium.

"I don't really think we'll find our Ohio-trained students going to third world countries to practice medicine," he says, defeating an often proposed argument that the U.S. has a worldwide responsibility to train

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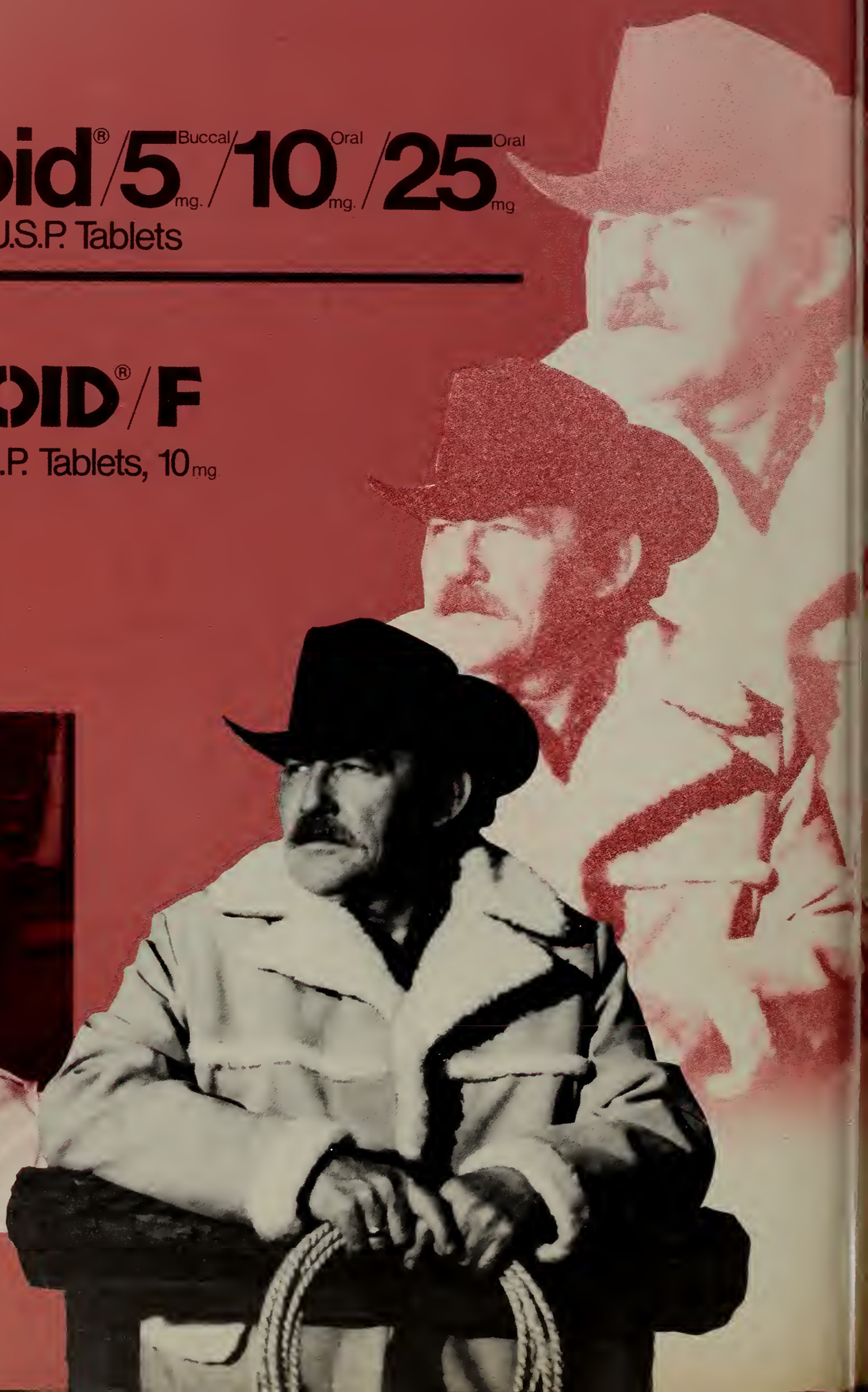
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Obituaries

PAUL BENNETT, MD, Portsmouth; University of Cincinnati, 1941; age 70; died May 26, 1984; member OSMA and AMA.

ROBERT J. EMSLIE, MD, Madisonville, Kentucky; University of Michigan Medical School, Ann Arbor, Michigan, 1929; age 82; died May 24, 1984; member OSMA and AMA.

CARL B. GEIGER, MD, Bluffton; Rush Medical College, Chicago, Illinois, 1929; age 82; died May 9, 1984; member OSMA and AMA.

JAMES G. JONES, MD, Cleveland; University of Cincinnati College of Medicine, 1920; age 88; died June 1, 1984.

ROSS M. KNOBLE, MD, Sandusky; Ohio State University College of Medicine, 1932; age 78; died May 22, 1984; member OSMA and AMA.

JAMES M. McBRIDE, MD, Lima; Indiana University School of Medicine, Indianapolis, Indiana, 1930; age 77; died May 10, 1984; member OSMA and AMA.

MAURICE MOSS, MD, Cleveland; Harvard Medical School, Boston, Massachusetts, 1953; age 56; died May 9, 1984; member OSMA and AMA.

ANDREW J. NEMECEK, MD, Cleveland; Ohio State University College of Medicine, 1926; age 88; died May 8, 1984; member OSMA and AMA.

JOHN RIESSER, MD, Dayton; University of Cincinnati College of Medicine, 1946; age 62; died May 5, 1984; member OSMA and AMA.

ALVYN W. TRAMER, MD, Shaker Heights; Case Western Reserve University School of Medicine, 1933; age 77; died May 27, 1984; member OSMA and AMA.

JOHN J. ZICKES, MD, Cleveland; Case Western Reserve University School of Medicine, 1927; age 81; died May 12, 1984; member OSMA and AMA.

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new look at the altruistic values of the profession.

"The doctor-patient relationship is a highly personal one. We want to believe that doctors place their patient's concerns above all else. But we know that's not always the case.

"We must acknowledge overdoctoring as well as underdoctoring. Greed is getting into the practice of medicine. With the legislation that has gone on in health care since 1965, the medical profession is losing sight of its social responsibility."

Physicians aren't the only ones at fault, however.

"Americans are deluded that more is better. Yet, 80% of medicine is inexact — leading to a gray area of medicine which the public does not yet fully understand."

Despite the outside forces which are slowly eroding the profession, can medicine still, in 1990, be the highly regarded profession it is today?

"If the profession takes a stronger moral stance, it can. Our professional leaders, too, should be selected for their vision of how the profession *should* be. The humanistic quality which has always been an integral part of our profession needs to be developed in today's medical students. Medical school admission boards need to look for that quality in candidates."

But Dr. Tarlov will be the first to admit that, like foretelling medicine's future, there are some things that are extremely difficult — if not impossible — to assess. **OSMA**

Karen S. Edwards is Executive Editor of the Ohio State Medical Journal.

It won't be as bad

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doctors. "You always have some doctors who are interested in missionary work, and certainly more physicians will be available in the future for that opportunity, but I don't really see an increase in that area."

He points out that more and more foreign medical graduates who come to the U.S. to receive their specialty training are staying in this country, rather than returning to their native country to practice. So, where does the responsibility lie?

"We need to cut out some of the American-born but foreign-educated medical students as well, but that's also something of a political issue. Haiti has just closed down its medical school, but our politicians are offering help to reopen the medical school in Granada."

So the surplus of physicians is coming from a number of different angles — and its coming to Ohio — bringing with it some obvious repercussions.

"But you can't be dogmatic about it. You can't really say how bad it's going to be. There is just no way to predict 1990 medicine in 1975, or whenever it was that we began the GMENAC study," Dr. Millhon says.

"Bad," after all, is a relative term — and just how "bad" the practice of medicine is going to be in 1990 is a question that no one can answer. But maybe, just maybe, Dr. Millhon will be right. Perhaps the oversupply problem of 1990 will be just as present — yet not nearly as bad — as the Big Brother government George Orwell painted for 1984. *Karen S. Edwards*

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The Numbers Crisis in Ohio

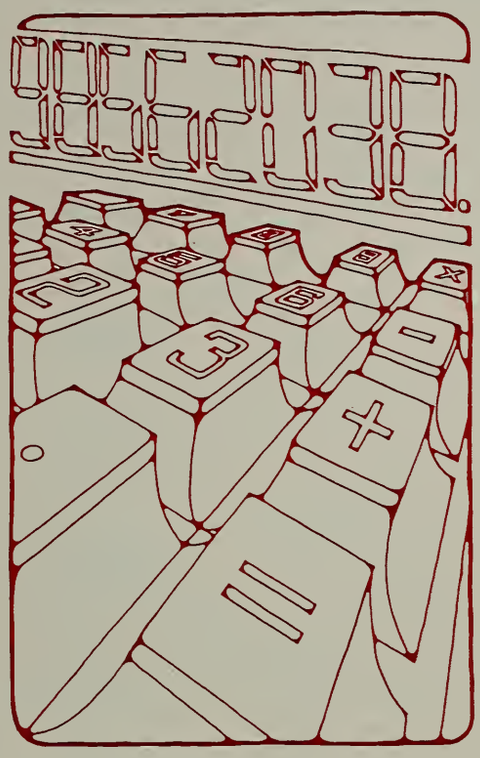
By David R. Rudy, MD

In the Medical Education Committee at Columbus' Riverside Methodist Hospital last spring, there were looks of apprehension as the Department of Medical Education (DME) announced the plans of the graduating residents. A greater proportion than ever, it was said, were taking salaried positions. Even now, at formal meetings, and in cloakroom conversations, references are made toward "Big Business" as a callous monster that would buy and sell doctors for "profit"; and to urgent care centers as opportunists that skim the cream without taking afterhours, not to mention longterm, responsibility for patients. Hospitals are increasingly seen as being in direct competition with their own staffs.

What seems to be unappreciated in the lounge seminars, however, may be the most important reason *why* physicians are subjected to more and more pressure from businesses and hospitals — and that is the numbers of physicians entering practice. While we must submit to government regulation, the only laws that businesses and hospitals have on their side are those of supply and demand. And unless current trends are reversed, time could be these facilities' greatest ally.

None of the nongovernmental entities referred to can cause physicians any anxiety without there being willing colleagues who will see patients for "the competition." Urgent care centers provide risk-free employment for newly graduating primary care practitioners (who are encountering increasingly saturated local markets). To the extent that hospitals enter the outpatient business (and they are doing so rapidly), they offer the same short-term advantages to the young doctor.

According to the Board of Regents' Report on Physician Manpower in Ohio (RPMO) of July, 1983, the state soon will have a positive "doctor balance" of more than 1,000 per year. This takes into account an attrition rate of 334 per year; an aggregate



graduating class in the state of 1,025 (by 1985); and an influx of more than 300 (based on the last two years).

The physician population already has moved from 10,000 to 17,000 in the period from 1970 to 1983, while the state's general population has nearly stood still (10.7 million to 10.8 million).

The most obvious cures for the numbers problem are apparently going to be bitter pills to administer.

According to the GMENAC Report, the U.S. population is expected to increase by 11% between 1978 and 1990 and by 19% between 1978 and the year 2000. The expected national increases in the physician population for the same two periods are 43% and 72% respectively, a rate roughly four times the growth of the general population. For the state, the general population is projected to increase by only 3% between 1978 and 1990 and by 7% between 1978 and 2000. Physicians in Ohio are increasing at about twelve times that rate. The foregoing comparisons of the state and the nation are summarized in Table 1.

Thus, while the nation is producing physicians at a rate 3.9 times faster than the population growth — an alarming statistic in itself — the State of Ohio is doing so at thrice the national rate.

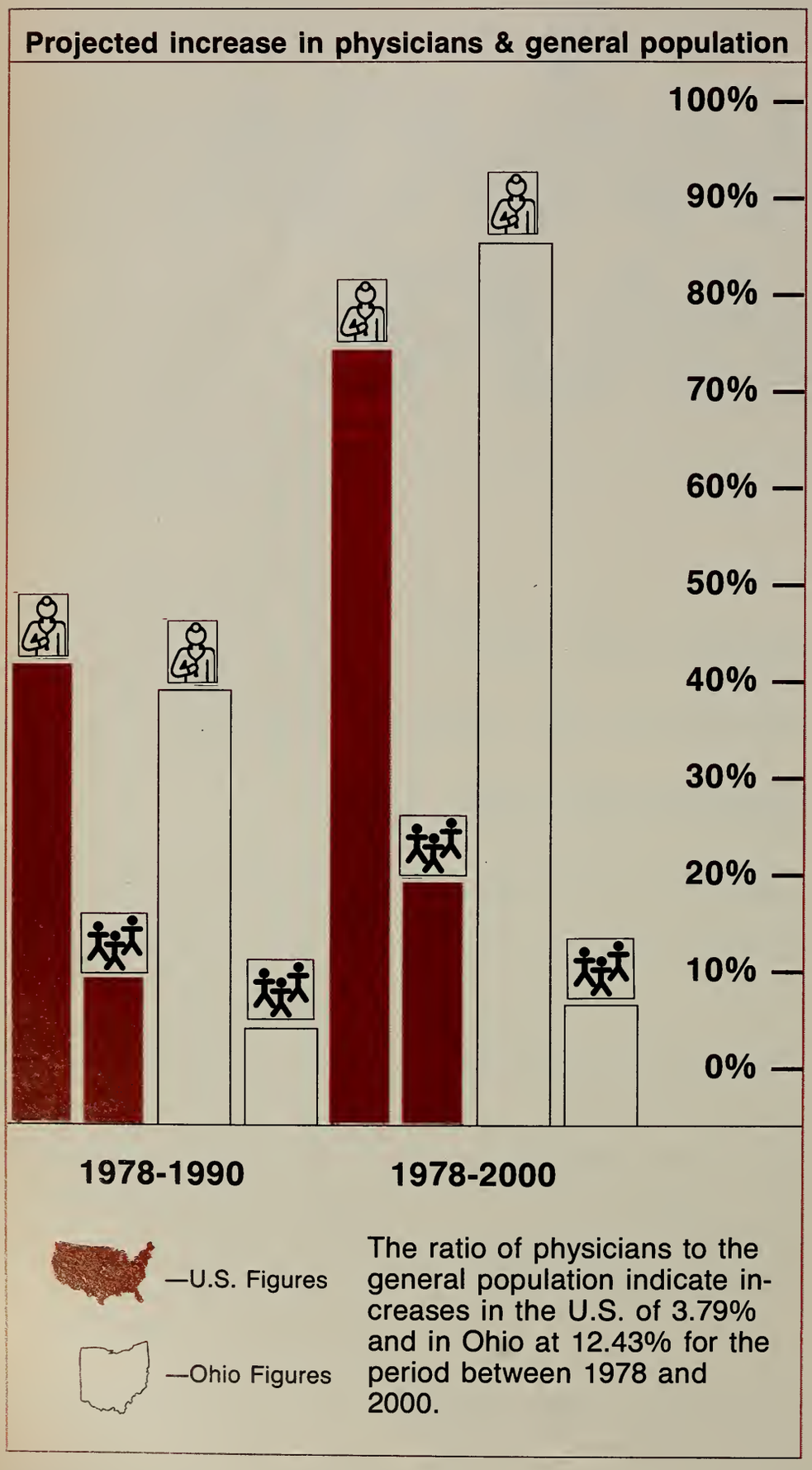
While these figures conjure up images of doctors moonlighting at carrying mail or tending bar in order to make ends meet, it seems that neither the "town" nor the "gown" segments of medicine have perceived the potential seriousness of the problem. However, before precipitate conclusions are drawn, several issues need to be addressed:

- First, what is the ideal physician-to-patient population ratio and what are the state's past, present and future situations in that regard?
- Second, what is the balance of physician immigration-emigration across the state line?
- Third, would a flux of physicians mend the maldistribution problem in the state?
- Fourth, when broken down by specialty, are there any groups which seem to be reproducing themselves at a particularly breakneck pace and conversely, any that might continue to be in short supply?
- Fifth, and perhaps most important, what does the numbers crisis portend for the quality and cost effectiveness of care in the state's future?

One can extrapolate data from both the RPMO report and GMENAC in order to address these crucial questions.

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TABLE 1



I. Ohio and the Ideal Physician-Population Ratio

The RPMO outlines the basis for establishing the following guidelines for ideal physician-population ratios:

Primary Care — 1:2,500
Non-Primary Care — 1:1,000
Total Active Physicians — 1.5:1,000

As of 1983, the state had reached about the correct overall ratio of 1.5:1,000, which is to say that the 70% increase in the state's doctor supply that took place between 1970 and 1983 had already wiped out the shortage of physicians that had existed. (The full increased production of graduating physicians affected by the addition of the three newest medical schools in the state will not occur until 1985).

As to primary care numbers in Ohio, in 1983 there was a narrow shortage of between 101 and 261, depending on whether one credits physicians over 65 years of age with half — or fulltime practice. This assumes the ideal ratio for primary care, of 1:2,500. Many assume 1:3,500 to be adequate.

For this discussion, primary care specialties are defined as family/general practice, general internal medicine and general pediatrics. The RPMO projects for Ohio the entrance of 2,000 new doctors into these fields between 1983 and 1990, when 116 per year would be required to balance the expected attrition rate. This results in a net increase of 1,304 physicians for that seven year period.

II. Ohio's Physician Import-Export Status

If Ohio were an exporter of physicians, the numbers could be somewhat alleviated (galling only in the unnecessary burden on the state's taxpayers of educating these physicians). However, Ohio is a net *importer* of physicians. According to the RPMO the average figures for 1981 and 1982 show that we *import* 99 more osteopaths and 125 more American-trained MDs per year than we export. In addition, we took in an average of 365 foreign medical graduates per year in each of those years. Taking the attrition rate of physicians through death, retirement and suspension to be 461, the net

importation of 589 more than balances the annual loss.

From the foregoing, it can be seen that the 224 net gain through importation of American-trained doctors, added to the 1,025 annual graduating classes of the seven schools leaves a positive balance of 1,153 doctors per year (with the FMGs roughly balancing the attrition rate). The import-export status is not helping the problem.

III. Geographic Distribution

It has been assumed that Ohio has a grave geographic maldistribution problem. According to the RPMO, if the minimum 1:3,500 physician-population ratio is applied, there are 17 counties with an aggregate need of 40 primary care physicians. If the ideal 1:2,500 were used, the number rises to 52 counties in need of a total of 260 doctors. This figure could be raised to 420 if one counts all those physicians of 65 years of age or older as half-time and discounts those in primary care specialties.

By these most liberal estimates of need, the rural primary care physician shortage could be met in less than three years at the present rate of production of family physicians, internists and pediatricians. Meanwhile, 967 unneeded doctors of other specialties will have been produced. If past experience portends the future, merely producing the primary care doctors will be no assurance that they will practice where they are most needed.

In short, the "sledge hammer" system which is presently in effect, will not necessarily drive doctors into the areas of greatest need and it will surely cause eventual disruption elsewhere. A better solution would be for the state to continue to encourage primary care residencies, as it is doing, while using a small portion of the present cost of excess physician production (some $50,000,000 per year) for more selective incentives aimed toward getting primary care doctors into the physician-poor areas. Meanwhile, the number of residency positions in specialties already in excess should be trimmed by official discouragement, if not direct

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TABLE 2

(TABLE 3 from GMENAC)

SUPPLY OF PHYSICIANS BY SPECIALTY 1978, AND ESTIMATES FOR 1990

	1978	1990 a/	Percent Change
All Physicians	374,800	535,750	+ 43
Osteopathic General Practice	13,550	23,850	+ 76
General/Family Practice	54,350	64,400	+ 18
General Pediatrics	23,800	37,750	+ 59
Pediatric Allergy	450	900	+100
Pediatric Cardiology	600	1,000	+ 67
Pediatric Endocrinology	N/A	250	N/A b/
Pediatric Hematology-Oncology	N/A	550	N/A b/
Pediatric Nephrology	N/A	200	N/A b/
Neonatology	N/A	700	N/A b/
General Internal Medicine	48,950	73,800	+ 51
Allergy and Immunology	2,100	3,050	+ 45
Cardiology	7,700	14,900	+ 94
Endocrinology	1,400	3,850	+175
Gastroenterology	2,900	6,900	+138
Hematology-Oncology	3,000	8,300	+177
Infectious Diseases	850	3,250	+282
Nephrology	1,450	4,850	+235
Pulmonary Diseases	2,800	6,950	+148
Rheumatology	1,000	3,000	+200
Neurology	4,850	8,650	+ 78
Dermatology	5,000	7,350	+ 47
Psychiatry (General)	25,250	30,500	+ 21
Child Psychiatry	3,050	4,100	+ 34
Obstetrics-Gynecology	23,100	34,450	+ 49
General Surgery	30,700	35,300	+ 15
Neurosurgery	3,000	5,100	+ 70
Ophthalmology	11,750	16,300	+ 39
Orthopedic Surgery	12,350	20,100	+ 63
Otolaryngology	6,100	8,500	+ 39
Plastic Surgery	2,600	3,900	+ 50
Thoracic Surgery	2,100	2,900	+ 38
Urology	7,100	9,350	+ 32
Emergency Medicine	5,000	9,250	+ 85
Preventive Medicine	6,100	5,550	– 9
Anesthesiology	14,850	19,450	+ 31
Nuclear Medicine	N/A	N/A	N/A c/
Pathology	12,650	16,850	+ 33
Physical Medicine & Rehabilitation	2,000	2,400	+ 20
Radiology	18,550	27,800	+ 50
All other and unspecified	14,000	9,700	– 31

N/A not available

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First-step blood pressure control with optimal simplicity

Benefits diuretics cannot offer . . . Once-daily INDERAL LA (propranolol HCl) provides smooth, 24-hour control of blood pressure plus the cardiovascular benefits of the world's leading beta blocker. And INDERAL LA provides a high degree of patient acceptance—without potassium problems.

Experience no other beta blocker can match . . . Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.



Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

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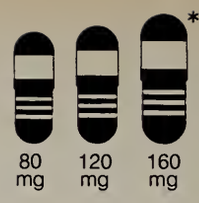
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(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement at any given level of effort by blocking the catecholamine-induced increase in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end-systolic pressure and systolic ejection period. The net physiologic effect of beta-receptor blockade is usually advantageous and is manifested during exercise by the relief of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the cerebral vessels.

Beta receptor blockade can be useful in conditions in which because of atherosclerosis or functional changes, sympathetic activity is detrimental but in which some beta-receptor activity is also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced [illegible] or neoplastic tumorigenic effects at any of the dosage levels. Reproduction studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses [illegible] greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; thrombosis of [illegible] thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

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legislation.

IV. Overpopulation by Specialties

As to representation of the specialties, it is safe to conclude from GMENAC data that if the overall ratio achieved as of 1983 is made up of a residual deficit of primary care practitioners, there is an abundance of non-primary care physicians.

Table 2 is a reproduction of Table 3 of the GMENAC Report. It tabulates the percentage rate of change of physician population by specialty between 1978 and 1990, nationwide. If one keeps in mind the expected population growth of 11% in the U.S. during the same interval, it is interesting to note, based upon the percentage increases in the various specialties projected, the current choices of residents in postdoctoral training.

Outstripping the population growth nationally by factors of 9 to 27 in the period 1978 to 1990 are all internal medicine subspecialties except allergy and immunology (4X) and primary care internal medicine (5X). The only fields that are reproducing at near or below the general population rate are allopathic general/family practice, physical medicine, psychiatry and preventive medicine.

If analogous comparisons are made for that period in Ohio (RPMO) the situation is, of course, more striking. Psychiatry, perhaps coming from behind, is increasing 12 times as rapidly as the general population. For four other major specialty areas, the figures are surgery (13X), Ob/Gyn (14X), internal medicine (27X) and pediatrics (28X).

Even in the case of family practice, as pointed out in section I, Ohio is rapidly outstripping the state's population and thus contrasts with the nation. Minor geographic maldistribution aside, the new specialty is reproducing at seven times the rate of the population.

V. Quality of Care, Cost Effectiveness, Physician Overproduction

According to the RPMO the numbers of students completing the process of application to medical schools in Ohio is not significantly greater than it was in the early 1970s when the aggregate class size was still less than 400. (It is now 1,025). Indeed, in the past five years the number has started a downward trend which will continue for some time, due to the passing of the postwar baby boom. (A saving grace may be recent news of a resurgence of child-bearing nationwide which presumably includes Ohio as well.)

In the year 1983, though around 1,500 initiated the lengthy application process, only 1,085 Ohio resident students completed it for the 1,025 seats. Moreover 250 were repeat applications from students who had been rejected in previous years. According to Professor Tennyson Williams of Ohio State University's Department of Family Medicine there were a number of out-of-state applicants equal to the Ohio applicants, at least at Ohio State. Data for the number of schools to which they applied in other states is not immediately available. About 20% of the medical student bodies of all except Case Western Reserve are from out of state. At Case Western the proportion is 40%.

The present overall chances, nationally, of a medical school applicant being accepted into medical school, according to Dr. Williams, is 1 in 2. This is up from 1:3 in the fifties and considerably from the days of the rush to humanism in the seventies.

Thus we now face the prospect of declining quality of medical students, on the basis of the relative decrease of the pool from which entering classes are chosen. It may be argued that academic prowess alone is not the best measurement of the quality of a physician. Nevertheless a ratio of 2:1 of applicants to medical school seats cuts at the selection process regardless of the criteria employed.

While the nation is producing physicians at a rate of 3.9 times faster than the population growth — an alarming statistic in itself — the State of Ohio is doing so at thrice the national rate.

CONCLUSION

The foregoing are conservative estimates of a great problem of physician oversupply which is rapidly taking shape in Ohio. In focal areas of the country where the physician-population ratio has become especially high, such as San Francisco (1:200), it appears that the population has benefited little except perhaps in having shorter waiting times at the doctor's office. Fees have not diminished and utilization of services has increased. Either the population's true medical needs have yet to be discovered, or there is a kind of Murphy's Law corollary which states that medical needs of a population will rise to meet the physician supply.

Recent world reports comparing physician supply to population health and longevity in various nations would suggest that a terribly high physician supply is not needed for high standards of health. For example, Japan, with the lowest physician-population ratio among industrialized nations, ranked number one.

The most obvious cures for the numbers problem are apparently going

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EXCLUSIVE

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No longer do doctors have to deny patients the benefit of an effective oral analgesic for fear of its misuse by injection.

Winthrop-Breon Laboratories has met a nagging problem by reformulating TALWIN® 50 (pentazocine HCl tablets) with the addition of naloxone, equivalent to 0.5 mg base. The reformulated product is called TALWIN® Nx.

The original formulation had been subject to a form of misuse among street abusers known as "T's and Blues." TALWIN 50 and PBZ,* an antihistamine, would be ground up together, put into solution, and injected intravenously. The combination produced a heroin-like high. Because naloxone is a narcotic antagonist when injected intravenously, it acts to nullify any high a "T's and Blues" addict might expect from the pentazocine in a combination of TALWIN Nx and PBZ. When taken as directed orally, the naloxone component of TALWIN Nx is inactive. Thus, TALWIN Nx continues to be a safe, effective, oral analgesic for the relief of moderate to severe pain, now providing added security against misuse.

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The reformulation of Talwin 50 to Talwin Nx involved the addition of 0.5 mg naloxone to help prevent misuse by injection.

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Each tablet contains pentazocine HCl, USP, equivalent to 50 mg base and naloxone HCl, USP, equivalent to 0.5 mg base.

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Contraindications: Hypersensitivity to either pentazocine or naloxone.

TALWIN® Nx is intended for oral use only. Severe, potentially lethal, reactions may result from misuse of TALWIN® Nx by injection either alone or in combination with other substances. (See **Drug Abuse and Dependence** section.)

Warnings: *Drug Dependence.* Can cause physical and psychological dependence. (See **Drug Abuse and Dependence**.) *Head Injury and Increased Intracranial Pressure.* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention; these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Can obscure the clinical course of patients with head injuries; in such patients, use with extreme caution and only if deemed essential. *Usage with Alcohol.* Due to potential for increased CNS depressant effects, alcohol should be used with caution. *Patients Receiving Narcotics.* Pentazocine is a mild narcotic antagonist. Withdrawal symptoms have occurred in patients previously given narcotics, including methadone. *Certain Respiratory Conditions.* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

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Adverse Reactions: *Cardiovascular:* Hypotension, tachycardia, syncope. *Respiratory:* Rarely, respiratory depression. *CNS. Acute CNS Manifestations:* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours; may recur if drug is reinstituted. *Other CNS Effects:* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor. *Gastrointestinal:* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress. *Allergic:* Edema of the face; dermatitis, including pruritus; flushed skin, including plethora. *Ophthalmic:* Visual blurring and focusing difficulty. *Hematologic:* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia. *Other:* Headache, chills, insomnia, weakness, urinary retention.

Drug Abuse and Dependence: *Controlled Substance.* TALWIN Nx is a Schedule IV controlled substance.

Dependence and withdrawal symptoms have been reported with orally administered pentazocine. Patients with a history of drug dependence should be under close supervision. Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported. In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient. Tolerance to the analgesic effect is rarely reported; there is no long-term experience with oral use of TALWIN Nx.

The amount of naloxone present (0.5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine; however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics. TALWIN Nx has a lower potential for parenteral misuse than the previous oral pentazocine formulation, but is still subject to patient misuse and abuse by the oral route.

Severe, even lethal, consequences may result from misuse of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion, ulceration and abscesses, and withdrawal symptoms in narcotic dependent individuals.

Overdosage: *Treatment:* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. For respiratory depression, parenteral naloxone is a specific and effective antagonist.

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The Numbers Crisis

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The rural primary care physician shortage could be met in less than three years at the present rate of production of family physicians, internists and pediatricians. Meanwhile, 967 unneeded doctors of other specialties will have been produced.

to be bitter pills to administer. The state has too many medical schools and the classes are too large. The solution? Eliminate one or perhaps two schools and cut the remaining classes by 20% or so. But which schools? None seems about to step forward in self sacrifice, nor are the residents of their regions ready to suggest to their legislators that these symbols of prestige be taken from their communities.

The deans are not anxious, given the present capitation method of reimbursement, to reduce their class sizes. One of the most hopeful suggestions is a reimbursement system that is flat and commensurate with an appropriate plan based on the relative size of each school compared to the others and designed to meet the needs of the state.

Various solutions to a state geographic distribution problem have been suggested which will not be given in this article. Suffice it to say, however that the task forces are already laboring to find incentives which are less expensive than the $50,000,000 annual price attached to the present cost of training an excess number of doctors.

The irony, of course, is that we may have created our own monster. During the sixties, we were made to feel guilty by angry activist groups who accused the medical profession of limiting its numbers to an elite group of favorites and progeny. Though few if any of us were party to such plans, we acknowledged that we were overworked and willingly turned to the planners for solutions to the problem that then existed. Now, however, it appears that the job of tackling the *oversupply* problem of the '80s will be just as difficult as tackling the undersupply problem of the turbulent '60s. Once again, we need the planners. But this time, there will be a sense of urgency as they turn to the task. **OSMA**

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TOMATOES
FRESH TOMATOES

WANTED:

A Few Good Doctors *For A Lot of Small Towns*

By Susan Porter

A dozen years ago, if anyone had even hinted at the phenomenon of a "physician surplus," he or she would have been laughed clear across the State of Ohio. Most doctors' work weeks were exhaustingly long, their waiting rooms overflowing with sick and temperamental patients who had waited days, if not weeks, for an appointment — only to have to wait hours to get from the waiting room to the examining table.

Throughout much of the state, the picture has changed, and where once doctors had to turn new patients away for a lack of time and resources, today, they are putting much of their time and resources into attracting new patients. Today, the words "physician surplus" are not likely to draw even a smile as they echo off the walls of many an empty waiting room.

But not everywhere.

For doctors in Morrow County, for instance, the physician shortage is as real today as it was in the early 1970s when state officials first became concerned about the future of health care in Ohio. At that time, the Ohio Board of Regents, anticipating a crisis in physician manpower, called for expansion of the medical school programs in this state, which resulted not only in increased class sizes at the four established medical schools, but also in the creation of three additional medical schools.

Today, these medical school graduates, along with an influx of physicians from outside the state and country, threaten to provide some areas with more medical care than they can possibly swallow. But this is not the case in Mt. Gilead, the seat of Morrow County, where waiting rooms are still burgeoning with patients, and some are forced to "procure a primary care physician from one of the surrounding areas," according to John Sweeney, MD, one of only six physicians in the county.

While most have been able to find care in the nearby cities of Marion, Mansfield or Delaware, "this tends to have a deteriorating effect on both the local community and the local hospital," says Dr. Sweeney, who has been in practice in Mt. Gilead since 1966. Not only do patients seek health care elsewhere; they also end up purchasing prescriptions, food and other consumer items while they are out of town. "And local people would prefer to doctor in their own communities," Dr. Sweeney adds.

It is for this reason that the citizens of Morrow County have formed HOST — Health Opportunity Search Team — a non-profit organization comprised of health care professionals, consumers and business leaders hoping to attract more physicians to the area.

"Part of the problem is we are *very* rural," says Jerry Tschudi, a physicians' supply salesman and the president of HOST. "We have a small hospital with limited facilities. It is not a teaching hospital with lots of nifty equipment and specialists. In residency programs, students are exposed to all of that. Because we don't have it, we tend to scare them away."

According to Dr. Sweeney, the county is in immediate need of two physicians and he projects it will need five more within the next five years. "Over the last four months, there has been some interest expressed by specialists who are looking at our area because they are no longer busy in the larger communities," he says. "But what we really need here are primary care physicians."

Morrow County is not alone in its problem. In fact, there currently are nine counties in the state — Putnam, Carroll, Morgan, Perry, Vinton, Warren, Preble, Noble and Monroe — which have no hospitals at all with which to attract physicians.

The need for family physicians is a problem throughout much of the state. According to a study completed two years ago by Lauren M. Brown, MD, and Tennyson Williams, MD, both with the Department of Family Medicine at the Ohio State University, "Ohio has approximately 50% the number of family physicans needed." (See February, 1982 *OSMA Journal*, "A Resurvey of Ohio Family Physicians.") Thus, as indicated in the conclusions of that study, "Ohio has a current (50%) deficit of family physicians," and "The deficit of family physicians will increase dramatically by the year 2000 as presently practicing family physicians cease to practice, unless replacement occurs."

While Vinton County currently remains the only one in Ohio with no resident physician, 11 other counties have less than 10 physicians each, according to the *Report on Physician Manpower in Ohio: Requirements, Supply and Cost*, published by the Ohio Board of Regents July 15, 1983. And nearly half of Ohio's counties — in part or in full — appear on the most recently completed listing of "Health Manpower Shortage Areas" (HMSAs), as designated by the federal government's Secretary of Health and Human Services.

HMSAs first were recognized in the early 1970s through the Emergency Health Personnel Act and its Amendments, when a scholarship program was set up to match needy medical students with underserved areas. Under the program, students pay off government loans by working either in special clinics or in private practice through the National Health

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Service Corps in those areas with designated shortages.

While seven types of health manpower shortages are designated, the category given the most attention and resources — and that deemed most critical — is "primary care." This includes those physicians in both general and family practice, internal medicine, pediatrics and obstetrics and/or gynecology, according to the program's definition.

HMSAs not only are determined by the area's ratio of primary care physicians to population (with a 1:3500 ratio as the bottom line), but also by its proximity (over 30 miles travel time) to adjacent areas where adequate supplies of primary care physicians exist. In addition, geographic barriers and certain socio-economic aspects of the area may be taken into consideration in determining whether there is a demonstrated need for primary care physicians in the area.

Some 42 Ohio counties contain HMSAs according to the August 19, 1983 *Federal Register* listing, currently in the process of being updated. Eight of these contain severe shortages (no physician at all or a physician/population ratio over 1:5000), while another 21 fall into the second most needy category (1:5000 to 1:4000, where need has been indicated).

Most areas with critical shortages are located in the southern portion of the state, in a semi-circle ranging all the way from the Hamilton area of Butler County in the southwestern part of the state, to the New Matamoras area of Washington County in southeastern Ohio. While most of these are rural counties — Highland, Vinton, Brown, Adams, Pike, Jackson and Lawrence — four Cincinnati neighborhoods in Hamilton County also are listed, including East End, Lincoln Heights, Price-Hill/Fairmont and Winton Hills.

Northeastern Ohio along the Pennsylvania border also contains a cluster of shortage areas, running from Jefferson to Mahoning counties and including Carroll and Columbiana. Similarly, on the northwestern Ohio/Indiana border, there are shortages in parts or all of Defiance, Henry and Paulding counties, as well as Putnam and Darke.

While less severe shortages exist in the northeastern corner of the state — in parts of Lake, Ashtabula and Geauga Counties — Cuyahoga County has a number of critical shortage areas, according to the listing, including sections of Cleveland, Collingwood, Cortlett/Lea Miles/Mt. Pleas, Glenville, Hough/Norwood, Jefferson/Puntas-Bellaire and South Broadway.

Other urban areas listed as HMSAs include the West Side of Dayton in Montgomery County; numerous sections of Toledo in Lucas County, including Center City, Downtown East Side, Near South Side, North Side and Old West End, along with Western Lucas County; and the entire East Side of Mahoning County.

As a result, "Thirty-eight National Health Service Corps (NHSC) physicians now serve in shortage areas" in Ohio, thus alleviating some of the need, "although the contribution of the NHSC is scheduled to decline after 1986," says the preliminary draft of a new section of the Ohio State Health Plan. (This new section, which is to concern itself with "Primary Care in Ohio," is currently in the process of being put together by the Ohio Department of Health.)

According to Terry Dole of the Department of Health, one reason the issue is being taken up by the state is because the NHSC program currently is being revised. While more emphasis will be placed on the program's Private Practice Option, which allows the indebted medical student to set up a private practice in a shortage area in lieu of working directly for the government in an area, fewer funds will be available to directly staff physicians in underserved areas.

The program also is expected to place more emphasis on rural HMSAs she says. But anticipated cutbacks in urban areas are likely to bring problems.

"Now, most all (NHSC workers) are electing the Private Practice Option," says Dole. "Very few areas have physicians hired directly by the government. The problem is that those areas which can't support a private practitioner, such as one HMSA in inner-city Cleveland comprised chiefly of winos, bag-ladies and other 'street people' may soon lose its clinic for lack of staffing."

One alternative for such clinics, she says, is to apply for status as a federally-funded community health center, another federal program which attempts to serve specially designated "Medically Underserved Areas"(MUAs).MUAs differ from HMSAs in a number of ways, Dole points out. While the latter generally address themselves to problems of geographic access to physicians, the former also take into account the demographics of the population served, including income, age, birth rates, and infant mortality rates.

According to Dole, the state currently operates eight rural health centers in MUAs, including programs in Perry, Vinton, Pike, Darke, Ross, Adams and Brown counties. In addition, five urban centers operate in the underserved areas of Cincinnati, Cleveland, Toledo and Youngstown.

Although criteria for HMSAs and MUAs differ somewhat, both consider a 1:3500 physician/population ratio to be a clear indication of shortage. However, the State of Ohio — both in its recent Board of Regents report and in its new Primary Care Component to the Ohio Health Plan — uses a more stringent 1:2500 ratio to indicate need (a compromise between the federal government guidelines and the 1:2000 ratio commonly used by HMOs and those countries with national health programs).

According to the May drafting of the Ohio State Health Plan, ". . . approximately 53 of Ohio's 88 counties have fewer than one primary care physician per every 2,500 people . . ." However, "Only 18 counties have a need for more than 5 doctors," it continues, and "the total number of physicians needed to bring all counties above the 1:2500 standard is about 300. . . ."

Still, for those many small communities in need of one or more of those 300 doctors — along with those areas within a 30 minute drive of an adequately supplied area, but which would prefer to have their own physicians — the statistics are not

comforting. It is for this reason that many, including Morrow County, are taking matters into their own hands. And some with good results.

For instance, a number of communities throughout the state have taken to raising funds in order to provide financial incentives to attract new physicians. A number have found help through the "Preferred Placement Program," (PPP) a privately-operated program initiated by the Medical College of Ohio in 1972. According to Marian C. Covrett, administrative assistant of that program, PPP "grew out of the need of one medical student here who needed the colossal sum of $9,000 to finish medical school so that he could go back and practice in his home town."

Howard S. Madigan, MD, now director of the program, took a personal interest in the student's plight and decided to pay a visit to the town fathers. The community agreed to loan the student the money to finish school — interest free — in exchange for his promise to set up practice in the town upon completion of his education. Today, that student not only continues to practice medicine there, but he also owns and operates a 60-acre farm in the community, Covrett says.

To date, some 29 communities throughout Ohio have committed over $1.6 million in support of 62 medical students, according to Dr. Madigan. "Currently, participants in the program are about divided — 50% are in practice, 25% each in residency and in medical school," he relates. And while in a few instances, the arrangement has not worked out, "thus far, the failure rate has been appreciably low," Dr. Madigan says.

Morrow County currently is one of those awaiting a new physician through the PPP program. According to Tschudi, HOST is hoping to raise some $30,000 — approximately one dollar for every man, woman and child in the county — to help fund the education of a Wright State University medical school junior who already has committed himself to the area when he finishes his schooling.

Still the wait will be a long one — at least five more years, including

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The most popular specialties in Ohio



Since 1910 when ophthalmology became medicine's first specialty area, there has been a trend away from the general practice of medicine towards increased specialization. As a result, while some areas are crying for primary care physicians, others attempt to support more than their share of general surgeons, urologists, radiologists, and in some locations, even psychiatrists.

Like the manpower issue, in general, the oversupply and undersupply in the specialty groups has to be considered on a location by location basis, says Lee Scroggins, president of Clayton L. Scroggins & Associates, Inc., a Cincinnati-based management and consulting firm for physicians. "Statistically, there is an undersupply of psychiatrists," Scroggins says, "but if you told that to the doctors in Cincinnati, they'd laugh. Specialists tend to cluster in certain areas. It's hard to make any statewide assumptions."

Tennyson Williams, MD, chairman of the department of family medicine at the Ohio State University, says that while medicine has grown increasingly specialized over the past 75 years, the total physician/population ratio has remained relatively stable. Therefore, for every medical school graduate choosing a residency in orthopedic surgery or neurology, a general practitioner is lost.

However, the limited capacity of physicians at the turn of the century, coupled with the sophisticated knowledge and technology used by today's family physician — not to mention the backup provided by the specialist — has more than balanced out the picture, Williams adds.

The following is a list of the ten most popular specialties in the state, followed by the most popular specialties in Ohio's three largest counties.*

OHIO

1.Internal Medicine	1,334
2.Family Practice	948
3.General Surgery	832
4.General Practice	761
5.OB/GYN	712
6.Pediatrics	556
7.Anesthesiology	526
8.Psychiatry	408
9.Radiology	383
10.Orthopedic Surgery	374

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residency — and, as Covrett puts it, "small towns tend to need doctors yesterday — not tomorrow." With its limited resources, PPP is attempting to convince communities to sponsor several medical students at the same time, in order to meet not only present but future needs.

And the problems are going to get worse, before they get better, Covrett fears. "The average small town physician is 54-56 years of age," she says. "There is going to be a big changeover in these towns over the next 10 years, and they need to start planning ahead for it."

Self-help programs like PPP are not a solution for everyone however, Covrett admits. She particularly points to "those isolated communities in the south/southeastern portions of the state" with high percentages of poor and elderly as good examples.

"Sometimes these areas are very depressed," she says. "There is no real industry. No hospital. The economy is bad and there is a large percentage of welfare patients. A doctor in the area would have to do a lot of traveling if he wanted to operate in conjunction with a hospital."

For these areas, more drastic help undoubtedly is needed, and it's questionable whether or not even a large surplus of physicians would ever solve the problem.

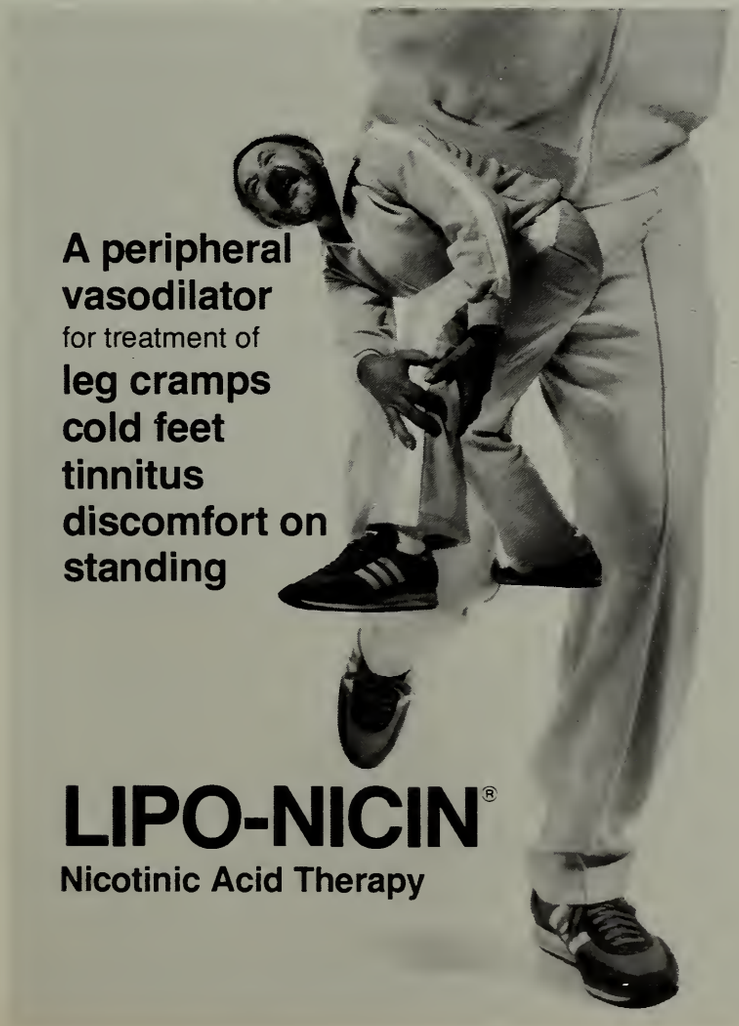
"In certain geographic areas it is not economically feasible for a doctor to be in practice," says Lee Scroggins, president of a Cincinnati-based management and consulting firm for doctors. "A doctor would have to see 80 patients a day — and he still may not cover his overhead, his personnel and his loans. If a doctor goes into a small community and he's the only one in town and Medicaid patients make up a large percentage of his practice — he just won't make it."

Money is not the only reason new physicians tend to steer clear of underserved areas. "Small communities tend to be very possessive," Scroggins says. "They want to know where their doctor is 24-hours-a-day." Most young physicians, on the other hand, "are looking for only 40 hours (of work) a week. A major goal is, 'how can I protect myself and my time?'"

Still, there are those who believe a healthy number of medical school graduates is bound to have some positive impact on the problem — that some of those 1,000 new physician graduates who come out of Ohio's medical schools each year eventually will seek patient loads along inner-city highways and small-town byways.

"They talk about the glut of doctors on the market," says Covrett. "But as we see it, there won't be a glut for a long, long time — not until all of these small towns have enough doctors." **OSMA**

Susan Porter is Assistant Editor of the Ohio State Medical Journal.



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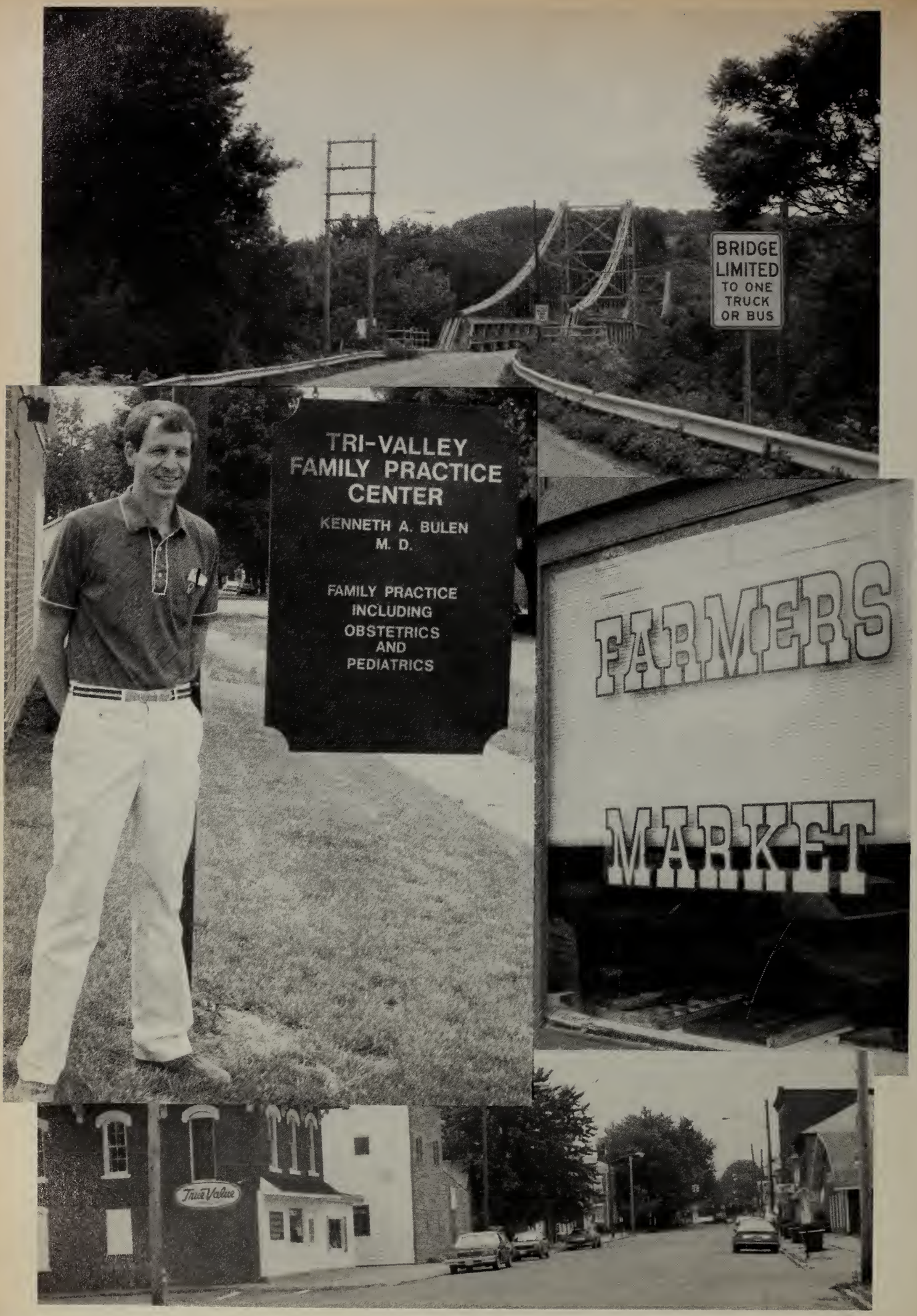
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Dresden Gets Its Family Doctor

By Susan Porter

Just a few short miles north of the Zanesville corporation line, State Route 60 takes a dramatic turn — from a congested, four-lane thoroughfare lined with gas stations and fast-food restaurants, to a two-lane country road which cuts through the rolling farmlands of Muskingum County. About 18 miles up that road lies the Village of Dresden, a sleepy little town of around 2,000 people, known chiefly for its unique handmade Longaberger baskets.

A booming canal town in the mid-1800s, the area was also rich in coal and other natural resources which drew miners and their families to this village on the banks of the Muskingum River. But the canal — like most of the mines — has long since been abandoned, with only a grassy dip in the terrain to mark its former location.

At one time, Dresden boasted three family physicians, and many of the surrounding communities had doctors of their own, as well. But gradually, they relocated, retired or died, leaving their patients to search for medical care elsewhere or — worse still — to go without it.

By the early 1970s, Dresden's only remaining physician had pulled in his shingle, continuing to see only a few select patients on a part-time basis. A few years later, he died, leaving the town with no local doctor at all.

A call went out for help, but it was muffled in the picturesque countryside which attracts Sunday drivers but few young professionals willing to make it home. Because Dresden is within a 30-minute drive to Zanesville — a city with a more than adequate supply of primary care physicians — it was not eligible for help from the federal government's National Health Service Corp; nor did its population, size or location warrant a government-supported community health center or clinic. So the people of Dresden and the surrounding Tri-Valley communities of Frazeysburg, Adamsville, Trinway and Adams Mills — went elsewhere for their care, traveling to Zanesville, Coshocton or Newark.

Until, that is, one year ago when Kenneth Bulen, MD, pulled into town in a 1970 Dodge Dart and decided to set up practice.

"My wife and I had done a lot of traveling — through Virginia and New England," he says. "I had been to the Carolinas and liked it there too." But everytime we'd leave the state, we'd ask ourselves, 'Do we really want to be this far from home?' "

The small-town life is not for everyone, he admits. While several new physicians have come to look over the town and the facility, few have returned for a second visit.

Dr. Bulen, who earned his MD from the Ohio State University in 1980 and did his family practice residency at the Akron General Medical Center, grew up in the small town of Enon near Springfield. His wife is a native of Warren.

"We like small towns and Dresden was perfect," he says. "It's about two-and-a-half hours from each of our hometowns — close enough that you can get there when you need to, but far enough away that the folks aren't stopping in every Sunday afternoon."

Dr. Bulen actually credits Bethesda Memorial Hospital in Zanesville for bringing him to Dresden. "Zanesville has two hospitals — Bethesda and Good Samaritan — and both of them are competing for patients," he says. Because Bethesda is on the north side of town, "it stands to gain a lot more from having a physician in Dresden," Dr. Bulen says, so it was actively recruiting a physician for the area.

Not only did the hospital promise to help him finance a new 2,000 square foot office complex, it also provided him with other economic assistance, such as covering his mortgage, overhead and paperwork his first six months in business. But while it was the hospital that first invited him to look around in Dresden, it was the town, itself, which convinced him he should stay.

"There's a tremendous amount of community pride and community spirit here," he says. "It's something that you just don't find in cities like Columbus or Akron. These are not the kind of people who sit back and wait for someone to come to their aid. If they need something, they go after it themselves."

Likewise, the people of the town were sensitive to his needs. Not only did they greet their new physician and his wife with numerous gifts, food baskets and receptions, but they also raised $20,000 to help him purchase the equipment he would need to start his practice.

Along with the community's positive attitude, Dr. Bulen also points

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Dresden Gets Its Family Doctor

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to the clean air, wide open spaces and slower pace of life that Dresden and many other small towns in Ohio have to offer. He and his wife recently purchased a home on over four acres of land, halfway between Zanesville and Dresden. The property backs up to a natural wildlife area, and "It's very peaceful out here," he says.

But the small-town life is not for everyone, he admits, glancing at his half-empty offices at the Tri-Valley Family Practice Center, a $142,000 facility "optimistically" designed for two. While several new physicians have come to look over the town and the facility, few have returned for a second visit.

"They look at the community and they don't feel they could be happy here," Dr. Bulen says. "They bring their wives and they see there's no shopping mall, no theater, no high-class restaurants, and their jaws drop."

Even those young doctors who, themselves, were raised in small towns generally have acclimated to city life and its advantages by the time they've finished eight years of medical school and a three-year residency, he points out. "They realize that they can have a much nicer lifestyle in the city where they can practice with three other partners who will share on-call duty with them on evenings and weekends," he says.

Physicians also face professional considerations when coming into small, underserved communities, Dr. Bulen points out. One reason, he, himself, did not even consider a number of communities in the more-needy southeastern part of the state was the lack of support facilities and personnel. "Coming from a fairly large community-based hospital in Akron, I was trained to use equipment and facilities found only in a certain-sized hospital," he says. "I learned to do a lot of things that I would never be able to do in a town served by a much smaller hospital or no hospital at all."

But the greatest problem facing the small-town doctor — and the reason most students steer clear of underserved areas — is the tremendous workload. "I was scared to death to come here by myself," he recalls. I was afraid I'd have a lot of work and no help — that emergencies would arise that I couldn't deal with alone — that I would be overworked and have no time for myself or my family."

All of his fears have been realized since he first opened his practice August 1, 1983, he admits. But he adds, "I've learned that all of that can be dealt with."

One way he deals with his workload is by limiting himself to a 60 to 70 hour work week, and subsequently referring some patients to other physicians out of the area. Another is by living several miles outside the town, itself. "The people here warned me that if I lived here in Dresden, I'd never get away from my work," he says. In addition, he has worked out an arrangement with several other physicians in the county to share on-call duty on weekends. And he's limited the number of Medicaid patients he sees — for financial reasons, as well as time constraints.

Still, overwork remains his greatest problem. "It is very difficult to preserve family and personal time — my emotional and mental health as well as my physical health," he says. "This has been my greatest problem. The practice of medicine is extremely challenging. But finding time for myself and my family is equally challenging."

A big part of the solution to this and other problems, he says, is realizing his limitations. "There is a tendency when you're out here in Dresden, Ohio, all by yourself, to try to assume all of the responsibility," he says. "You learn very quickly you just can't do that. I could easily work 12 to 14 hours a day, every day, and still not fill all of the need. I had to learn that it's not a sign of deficiency on my part. I just can't handle everything."

Part of the problem lies in the specialty of family medicine, which, Dr. Bulen defines as "a jack of all trades and a master of none." He explains, "Most doctors have Type-A personalities — they are high achievers who want to be the best at what they do. Yet a family practitioner is not the best at anything. We have a vast breadth of knowledge, but we're not the best in any one area.

"We learn in medical school that the family doctor can handle nine out of ten problems in the office — and that's a good percentage. But that still means that in one out of ten cases you're going to need some help. If you're seeing 150 patients a week, there will be 15 cases or so that are going to give you some trouble."

It is for this reason that he considers

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Specialties

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HAMILTON COUNTY

1.Internal Medicine	211
2.OB/GYN	100
3.Family Practice	95
4.Psychiatry	94
5.General Surgery	88
6.Pediatrics	85
7.General Practice	61
8.Anesthesiology	58
9.Ophthalmology	55
10.Orthopedic Surgery	53

CUYAHOGA COUNTY

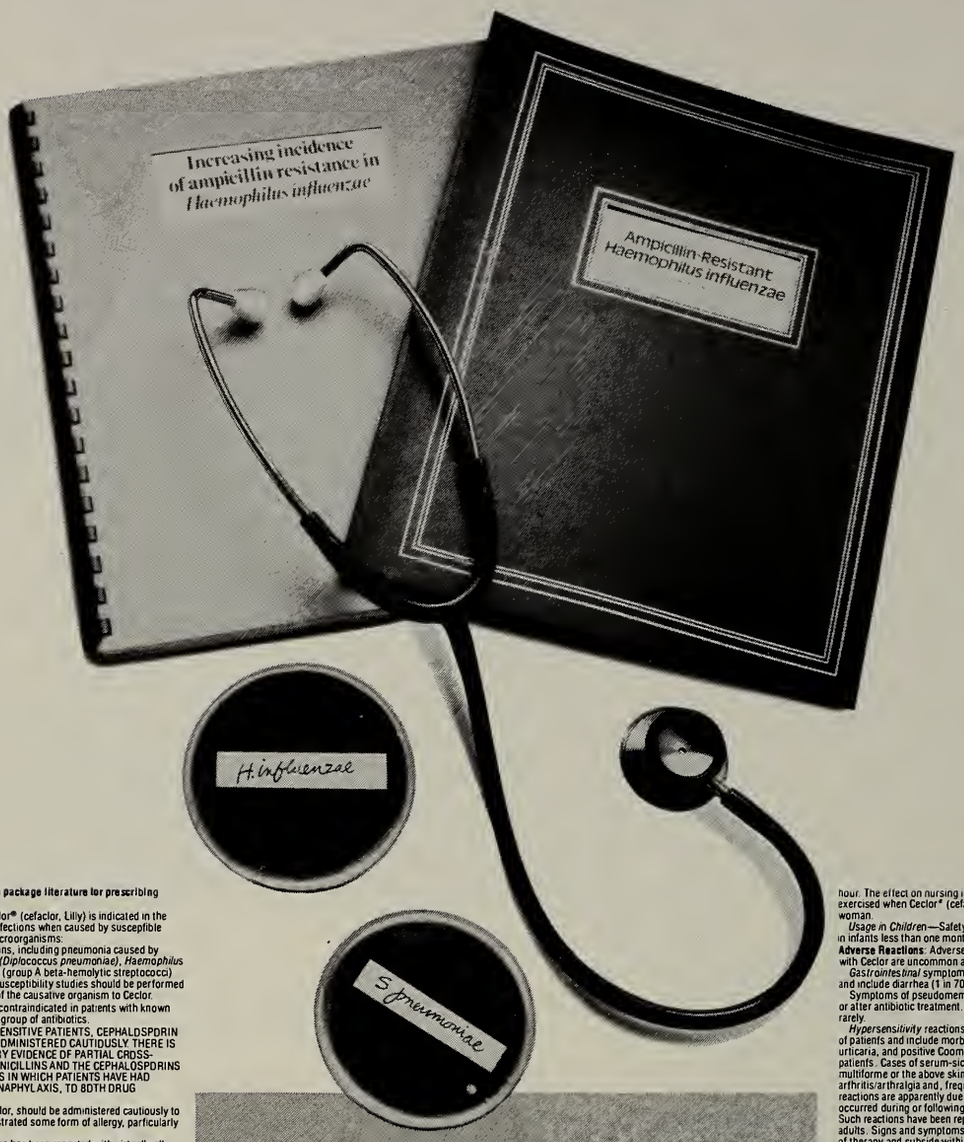
1.Internal Medicine	296
2.General Surgery	166
3.OB/GYN	135
4.Anesthesiology	117
5.Pediatrics	104
6.Psychiatry	91
7.Radiology	93
8.Orthopedic Surgery	74
9.Ophthalmology	73
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FRANKLIN COUNTY

1.Internal Medicine	108
2.Family Practice	74
3.OB/GYN	60
4.Anesthesiology	53
5.Psychiatry	51
6.General Surgery	47
7.Orthopedic Surgery	46
8.Pediatrics	45
9.Opthalmology	44
10.General Practice	40

*Based on OSMA membership totals of active practicing physicians as of 6/4/84.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGDT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York John Wiley & Sons, 1979.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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Carolina, Puerto Rico 00630

300035

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the town's newly purchased (through a local community fund raising effort) emergency squad vehicle and Zanesville's two well-equipped and nearby hospitals his salvation. "In many ways, I have the best of both worlds," he says.

With over 1,500 patients already under his care and the potential for ten to twenty times that number, Dr. Bulen says Dresden could easily support one or two additional physicians. And he has a hard time sympathizing with fellow physicians in more populated areas of the state who now are having to compete for adequate patient loads. Yet he admits that competition was part of what nudged him towards a family practice in an underserved area. "I didn't want to go somewhere where they already had 14 family doctors," he says.

A big part of the reward is the self-satisfaction that comes from being truly needed. "The people are so grateful. You really begin to feel what it's like to help someone else."

Like many of his colleagues, he also was tempted to take a salaried position with an HMO. "It's an easy answer," he says. "You don't have to go into debt or put out money for equipment. There's minimal financial risk. You work certain hours and your free time is your own. There are a lot of obvious advantages." But, he adds, "If you don't make the investment, if you don't take the risk, you don't get the rewards, either."

A big part of that reward for Dr. Bulen — and the one that most often makes up for the big debts, long hours, lack of personal time and bouts with self-esteem — is the self-satisfaction that comes from being truly needed. "The people are so grateful," he says ."You really begin to feel what it's like to help someone else."

And he highly recommends the job to others who want to practice *real* family medicine — but with certain considerations. "First of all, you have to be interested in small communities,' he says. "You have to be able to enjoy a small town and what it has to offer. And then you have to look at that community's need as a challenge — rather than a burden."

He continues, "If you're used to having a shopping mall, a theater or a major sports facility right down the street, you're probably not going to make it here. And if you know you won't be happy in a small town, then you don't belong here just because there's a shortage.

"But if you enjoy fishing, hiking, fresh air, the outdoors and working with people — there are still some great opportunities out there for you



Dr. Ken Bulen

— in Dresden, Millersburg, Jackson Center — and many other small communities in Ohio. **OSMA**

Susan Porter is Assistant Editor of the **Ohio State Medical Journal.**

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New Drug Formulary Implemented

The Ohio Medicaid Drug Formulary will undergo some changes effective September 1, 1984 in the therapeutic categories of vitamins, nutritional products, blood modifiers, hormones, and related products. The changes are being implemented to allow for cost containment without jeopardizing the health care of recipients or severely limiting the ability of physicians to prescribe for that care.

Most of the vitamin-iron combinations will be removed from the Formulary. They have been replaced by cost effective vitamin formulations having at least 100% RDA of essential vitamins. To prescribe multiple vitamins for your patients you can now make one of the following choices:

MINIMUM CONTENT REQUIREMENTS PER DOSE FOR MULTIPLE VITAMIN PRODUCTS

VITAMIN B-COMPLEX-C: B1-15 MG, B2-15 MG, B3-100 MG, B6-4 MG, B12-6 MCG, C-500 MG, E-30 U, Folic Acid-0.4 MG.

VITAMIN CHEWABLE: A-2500 U, D-400 U, B1-1 MG, B2-1.2 MG, B3-13.5 MG, B6-1 MG, B12-4.5 MCG, C-60 MG, E-15 U, Folic Acid-0.3 MG.

VITAMIN CHEWABLE W/FE: Added iron-12 Mg.

VITAMIN CHEWABLE W/F: Added fluoride-1 MG

VITAMIN DROPS: A-1500 U, D-400 U, B1-0.5 MG, B2-06 MG, B3-8 MG, B6-0.4 MG, B12-2 MCG, C-35 MG, E-5 U

VITAMIN DROPS W/FE: Added iron — 10 MG

VITAMIN DROPS W/F: Added fluoride — 0.5 MG

VITAMIN MULTIPLE DAILY: A-5,000 U, D-400 U, B1-1.5 MG, B2-1.7 MG, B3-19 MG, B6-2.0 MG, B12-3 MCG, C-60 MG, E-15 U, Folic Acid-0.4 MG

VITAMIN MULTIPLE DAILY W/FE: Added iron-18 MG.

VITAMIN MULTIPLE DAILY W/MIN: Added minerals.

VITAMIN THERAPEUTIC: A-8333 U, D-133 U, B1-3.3 MG, B2-3.3 MG, B3-33.3 MG, B5-11.7 MG, B6-3.3 MG, B12-50 MCG, C-100 MG, E-5 U, FE-66.7 MG, Folic Acid-0.33 MG.

The baby vitamins, children's chewables, and prenatals have all been expanded to permit the prescribing of cost effective, over-the-counter products and generics. It is no longer necessary to prescribe vitamins with fluoride unless appropriate. Approximately 81% of Ohio's water is fluoridated.

For ambulatory patients, these vitamin products *must* be prescribed in full package sizes ie: 100's for tablets and capsules, 50 ML for drops, etc. It is permissible to prescribe smaller quantities initially to determine patient-drug compatibility.

Larobec, which is included in the proposed multiple vitamin deletions, may be prior authorized if the patient whose drug regimen includes Levodopa requires a multiple vitamin supplement.

For your patients requiring additional iron, you may now prescribe ferrous gluconate 5 gr tablets, or ferrous sulfate in 5 gr tablets, sustained release capsules, drops and elixir. These products must be prescribed in full package sizes, and trial prescriptions of smaller quantities will be permissible on a one-time basis only.

The potassium effervescent tablets and powders are proposed to be removed from the Formulary in favor of more cost effective liquids, oral tablets, and capsules. The liquids have been expanded to include 5% and 15% solutions to permit more versatility in attaining the proper MEQ dosage. The number of MEQ potassium per tablespoonful (15 ML) of liquid will always be twice the percentage number. As an example, a 20% solution will yield 40 MEQ per tablespoonful. A generic effervescent potassium chloride tablet will be on the Formulary having 25 MEQ/tablet.

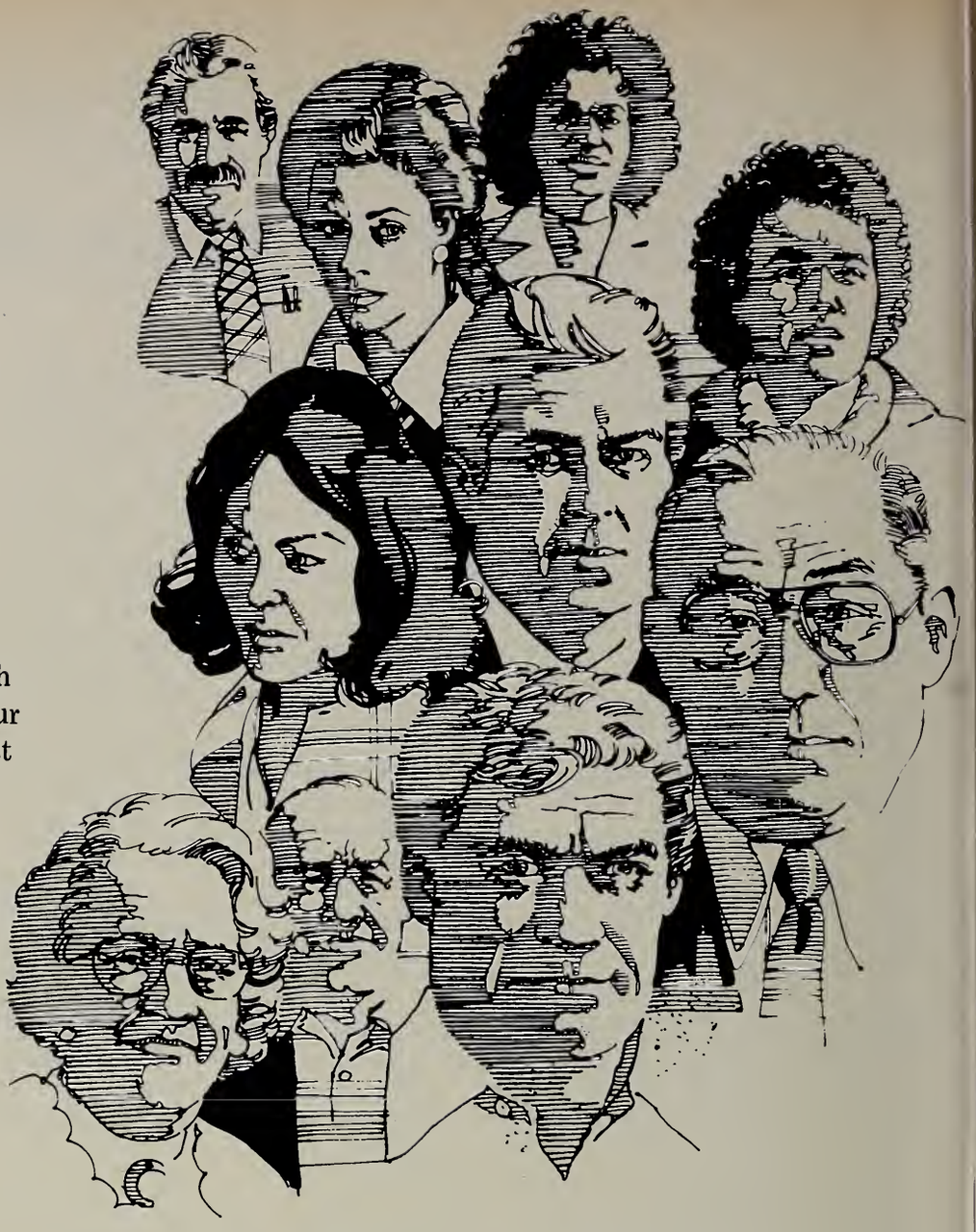
Physicians Surveyed for RX Habits

More than 275,000 of the nation's physicians will be surveyed this year to develop detailed information on their drug prescribing habits, part of a comprehensive national physician information exchange program. Data gathered by the survey will be provided to both physicians and pharmaceutical companies to increase their understanding of physician prescribing habits. "The survey data provides physicians with a practical tool for comparing their own prescribing practices with those from a comprehensive national sample. The survey provides pharmaceutical companies with a unique guide to which drugs are being used," remarked Richard J. Hammel, PhD, an official of McKesson's Physician Information Exchange, which is conducting the survey.



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Portal Hypertension

By Neil R. Thomford, MD

Portal vein hypertension is a consequence of interference with the normal return of splanchnic venous blood to the heart. The resulting development of compensatory venous pathways from the abdomen to the chest is responsible for the appearance of submucosal varices in the stomach and esophagus; varices which all too often are the source of life threatening hemorrhage.

Today, gastroesophageal varices is the source of bleeding in one of every ten patients with upper gastrointestinal hemorrhage. A variety of diseases may produce varices by impeding splanchnic venous return at the prehepatic or posthepatic levels but in the vast majority of cases the site of obstruction is within the liver and is the result of cirrhosis of the liver. Portal hypertension, although only a secondary hemodynamic phenomenon, is the critical link in this major health problem of cirrhosis of the liver and bleeding esophageal varices. The importance of portal hypertension to the medical profession relates to the steady and alarming increase in the incidence of cirrhosis and the difficult and demanding problem of controlling hemorrhage from gastroesophageal varices.

HISTORICAL PERSPECTIVE

The association of esophageal varices with cirrhosis and splenomegaly was described in the medical literature by several authors in the early and mid 1800s but liver disease was not generally appreciated to be the predominant cause of portal hypertension until the 1930s.[1] This delay was, in large part, the result of a report by Banti in the 1880s in which he described a group of patients with cirrhosis of the liver, splenomegaly and anemia, many of whom also had bouts of hematemesis.[2] Banti suggested the problem was the result of a disorder of the spleen with a secondary cirrhosis of the liver produced by a toxin released from the spleen. This theory prevailed until the 1930s when primary disease of the liver was recognized as the principal cause of portal vein hypertension and the resulting congestive splenomegaly.

Since the 1940s splanchnic to systemic venous shunts have been the preferred method of managing bleeding from varices due to hepatic cirrhosis. For the first twenty years, the portacaval shunt was the unchallenged favorite of surgeons.[1] Then, controlled trials provided the unexpected conclusion that although the portacaval shunt effectively controlled hemorrhage it did not prolong the lives of these desperately ill patients.[3] It simply changed the mode of death from hemorrhage to hepatic failure. This knowledge rekindled efforts to develop alternative and improved methods for treating patients with bleeding from gastroesophageal varices. Radiologists, pharmacologists, endoscopists and surgeons have subsequently provided us with a variety of measures for arresting and preventing recurrence of hemorrhage. At this time, however, only shunt operations are recognized as providing predictable long term protection from hemorrhage.

CURRENT MANAGEMENT OF PATIENTS WITH BLEEDING VARICES

The initial treatment of patients with portal hypertension and bleeding from esophageal varices should be medical. The continuous infusion of pitressin through a peripheral vein will substantially lower portal vein pressure and is our most practical and predictable tool for arresting variceal hemorrhage. In some instances, tamponade of varices with one of the balloon tubes may be necessary. Every effort must be made to avoid an emergency operation with its attendant errors in diagnosis, inadequate preoperative evaluation of hepatic reserve and unacceptable mortality. Still, it must be recognized that in a small percent of patients, medical measures will fail to stop the hemorrhage and an urgent or emergency operation will be necessary.

When hemorrhage cannot be controlled and the loss of blood exceeds 1500 milliliters per 24 hours, operation must be advised. Delay continues to be a common error. Unsuccessful medical measures are continued too long and the rate and volume of blood loss is all too often far in excess of that which would have precipitated a decision for operation if the working diagnosis had been hemorrhage from a lesion other than varices. Given the availability of interruption of the varices of the distal esophagus with a stapling instrument or rapid splanchnic venous decompression with the mesocaval interposition shunt all patients who are judged to be candidates for operation should undergo early operation if hemorrhage cannot be controlled.

For those who continue to bleed and operation is judged unacceptable, percutaneous transhepatic catheterization of the coronary vein for the purpose of causing thrombosis of that vessel and transesophageal injection of varices with a sclerosing agent offer alternative methods of treatment with established efficacy. The selection of a method of management for patients who fail to respond to pitressin and balloon tamponade is currently largely

continued on next page

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determined by the expertise and interest of the medical staff of the institution where the patient is admitted.

When hemorrhage stops spontaneously or in response to medical measures, prompt evaluation should be undertaken to determine if the patient is a candidate for a definitive operation to prevent recurrent hemorrhage. If so, the operation should be planned for the earliest possible date. In some instances, a brief delay may be advisable. If the hemorrhage caused significant deterioration in hepatic function, the risk of recurrent hemorrhage may be offset by the advantage of the recovery of hepatic reserve associated with waiting for a brief period.

Among procedures available for long term control of variceal hemorrhage, the distal splenorenal shunt is emerging as the standard against which other methods must be measured. This shunt, described in 1967 by Warren, Zeppa and Forman,[4] was designed to provide selective decompression of the venous hypertension in varices of the esophagus and proximal stomach while preserving hypertension in the mesenteric and portal veins. The central end of the splenic vein is dissected free of the pancreas, is ligated at its junction with the superior mesenteric vein and an end to side splenorenal anastomosis is established. As a result, blood in varices at the gastroesophageal junction flows through the short gastric vessels into the spleen and out the splenic vein into the left renal vein. A major consideration of the procedure is to avoid insult to the already diseased liver by preserving portal vein hypertension and maintaining venous inflow to the liver. As a result, the devastating effect upon the diseased liver of sudden diversion of portal inflow is avoided and the direct shunting of splanchnic venous blood into the systemic venous circuit is limited. There is general agreement, however, that the distal splenorenal shunt is often a technically difficult and demanding procedure.

When technical factors preclude the establishment of a distal splenorenal shunt, an alternative shunt or a non-shunt operation such as a devascularization procedure may need to be selected in an attempt to prevent recurrent hemorrhage. Finally, when the risk of any elective operation is unacceptable because of the severity of the liver disease or associated disease, transesophageal sclerotherapy is today the best alternative.

The ultimate solution for this health care problem lies with the prevention of alcoholism and hepatitis, the principal causes of cirrhosis of the liver. An alternative answer and perhaps an interim solution for variceal bleeding is the development of long-term pharmacologic control of portal hypertension. **OSMA**

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MINUTES NEXT MONTH

Due to publication deadlines, the minutes of the annual meeting of the OSMA House of Delegates will not appear until next month's (September) issue of the *Ohio State Medical Journal.*

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References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

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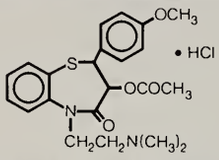
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Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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August

IMPORTANT ISSUES AND DEVELOPMENTS IN OBSTETRICS AND GYNECOLOGY: August 10-12; Kings Island Inn; sponsor: Department of Obstetrics and Gynecology, University of Cincinnati; 17 credit hours; fee: $350, $250 for residents; contact: Stanley J. Stys, M.D., University of Cincinnati, M.L. #526, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-4277.

September

UPDATE IN PULMONARY DISEASE: September 5-7; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 15 credit hours; fee: $180, $120 for physicians-in-training; contact: Center for CME, The Cleveland Clinic Educational Foundation; 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio: 1-800-762-8172; Outside Ohio: 1-800-762-8173.

14TH ANNUAL PERIPHERAL VASCULAR DISEASE SYMPOSIUM: September 6-8; University Hilton Inn, Columbus; sponsor: St. Anthony Hospital, Columbus; 17 credit hours; fee: $250; contact: Pat McGlone, RN, MS, Saint Anthony Hospital, Vascular Lab/T-11, 1450 Hawthorne Avenue, Columbus 43203, phone: 614/251-3680.

PEDIATRIC AND ADOLESCENT GYNECOLOGY — 1984: September 11-12; Bunts Auditorium, Cleveland Clinic; sponsor: The Cleveland Clinic Foundation; 12 credit hours; fee: $150, $100 for physicians-in-training; contact: Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio: 1-800-762-8172; Outside Ohio: 1-800-762-8173.

FOURTH ANNUAL WORKSHOP IN FERTILITY MICROSURGERY, IN VITRO FERTILIZATION, AND STERILIZATION REVERSAL: September 12-15; sponsor: Mt. Sinai Medical Center, Cleveland; cosponsor: Case Western Reserve University; 30 credit hours; fee: $850, $650 for residents; contact: Secretary, Department of OB/GYN, Mt. Sinai Medical Center, University Circle, Cleveland 44106, phone: 216/421-4607.

HOME CARE — A FUTURE DIRECTION IN MEDICINE: September 13-15; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; sponsor: The Cleveland Clinic Foundation; 15 credit hours; fee: $200; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio: 1-800-762-8172; Outside Ohio: 1-800-762-8173.

WEEKEND MEDICAL UPDATE: September 14-16; Sawmill Creek Lodge, Huron; sponsor: Cleveland Clinic Foundation; 15 credit hours; fee: $195, $150 for residents; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio: 1-800-762-8172; Outside Ohio: 1-800-762-8173.

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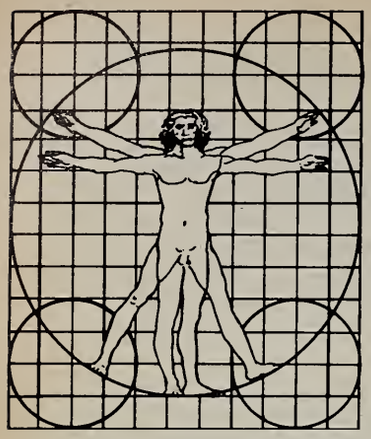
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CLINICAL & SCIENTIFIC

Primary Dysmenorrhea: Current Concepts

Stephen J. Voto
Garth F. Essig, MD

Primary dysmenorrhea is a condition of painful menstruation affecting approximately 50% of menstruating women. Classification of this disease is differentiated from secondary dysmenorrhea in which pelvic pathology can be demonstrated. The etiology of primary dysmenorrhea has been attributed to many factors, such as behavioral and psychologic factors, uterine ischemia, increase of uterine prostaglandins and arginine vasopressin. Prostaglandins appear to be the major contributing factor in the pathophysiology of primary dysmenorrhea. Medical management includes the use of oral contraceptives and nonsteroidal anti-inflammatory drugs (NSAIDs). It is from this therapy that anywhere from 61% to 94% of women have experienced relief from their symptoms. When relief is not found in 6 to 12 months, it is recommended that occult pelvic pathology be ruled out.

Introduction

Primary dysmenorrhea is the most common gynecologic complaint heard by physicians today. It perhaps was one of the least understood topics until the recent surge of evidence indicating the relationship of endometrial prostaglandins as an etiologic agent to painful menstrual flow. This disabling condition has been reported to affect approximately 50% of menstruating women and cause an estimated 140 million lost work hours, annually.[1]

Primary dysmenorrhea is a symptom-complex referring to painful menstruation. This excludes secondary dysmenorrhea,[2] in which demonstrated pelvic pathology is present, and premenstrual syndrome.[3] Due to the lack of structure in definition of this disorder, the percentages of women affected have been reported to vary from 6% to 70%, depending on the: 1) age, usually not present at menarche but appears a year or two later, increasing from age 23-27 and gradually declining with age; 2) parity, nulliparous more so than multiparous; 3) weight, obese have greater risk, 4) economic class, higher more so than lower; and 5) menstrual characteristics, irregularity is often a common factor.[3]

This report presents the history, etiology, the relationship of prostaglandins to primary dysmenorrhea, a review of old and new drugs used in the treatment and an outlook on future research.

From The Ohio State University, Department of Obstetrics and Gynecology
Submitted July 20, 1983

History

The history of dysmenorrhea dates back to the Greeks who defined the word as "painful menstrual flow."[3] Hippocrates described the condition as stagnation of menstrual blood, secondary to obstruction of the cervix, for which he prescribed a fumigation of the external genitalia by the scents of rose oil, fennel seed and root, and sweet wine. The combination of tansy, hoarhound, wormwood, catnip, and hops were prescribed by 19th century American physicians to be heated and stood over.[1]

Chinese used acupuncture and moxibustion which was a cone of wormwood on a piece of ginger, placed on the abdomen, then ignited and allowed to burn.[1]

Even more outlandish was the 18th to 19th century use of hot cupping glasses or suction cups applied to the breasts, thought to relieve the pain; this developed from the belief, at the time, that the breasts and uterus were connected sympathetically.[1]

Next was the pharmacologic expansion into the late 19th and early 20th centuries. Powerful analgesics, such as opium and its derivatives, were used along with cannabis and various alcohol preparations.[1]

In 1865, the first surgical approach was used, consisting of a bilateral oophorectomy followed by such procedures as external and internal radiation, hysterectomy, presacral neurectomy and dilation and curettage.[1]

The relationship of dysmenorrhea and ovulation was discovered in 1938 and was adequately treated by ovulatory suppression with estrogen.[4] Yet, even though a large population of women responded to therapy with an estrogen-progesterone preparation to suppress ovulation, there also existed a group who responded to hormonal therapy which did not suppress ovulation (i.e., methyltestosterone[5] and dydrogesterone[6]).

Even more confusing is the relationship to progesterone. It was felt that the reason dysmenorrhea did not surface until one to two years post-menarche was that these years were mostly monophasic-anovulatory cycles.[7] However, there was a large population which described dysmenorrhea as early as the first menstrual period.[8] Finally, exogenously administered progesterone has been shown to relieve dysmenorrhea via intrauterine releasing device.[9]

Being overshadowed at this time was work that has been dated back as far as 1934[10] which indicated a relationship in most dysmenorrheic patients of uterine contractions during menses (sometimes reaching three to four times normal) which correlated well with episodes of pain and has been proven in a controlled study.[11] It wasn't until 1957 that a smooth muscle contractant was identified[12] (now known as prostaglandins) and

would be later implicated as the causative compound.[13]

The psychogenic theory was advanced in the 1940s and many feel still remains part of the etiology of dysmenorrhea.[14]

So in all, until the discovery of prostaglandins and the subsequent relationship of them to dysmenorrhea, the known therapies were oral contraceptives, childbirth, sedation, narcotic analgesics, other hormones to suppress ovulation, and just plain bed rest.[1,4]

Etiology

A. Dysmenorrhea and Prostaglandins

The relationship of prostaglandins to primary dysmenorrhea is probably the best explanation medical science can offer, to date, for this sometimes severely afflicting disorder. Prostaglandins are thought by many as the etiologic agent of disease. Many of the major details have been worked out for prostaglandins in the pathogenesis of dysmenorrhea.[1,4,15]

1) Prostaglandins $PGF_2\alpha$ and to a lesser extent PGE are increased in menstrual fluid at the time of menstruation in dysmenorrheic women when compared to matched controls.

2) That these increased levels correlate well with pain and the amount of pressure per uterine contraction.

3) The infusion of $PGF_2\alpha$ and PGE reproduce the same signs (i.e., increased uterine contractility and motility) and symptoms (i.e., increased menstrual pain, headaches, nausea, vomiting, and personality changes).

4) Prostaglandins produce histologic changes in the uterus specifically contraction of arteriolar beds, which may be the genesis of pain, producing uterine ischemia and anoxia, sometimes called "uterine angina." Next, the uterus mounts a potentiated response further releasing prostaglandins due to endometrial necrosis.

5) Most importantly, the inhibition of prostaglandin synthesis by the use of nonsteroidal anti-inflammatory drugs (NSAIDs), has relieved significantly pain in greater than 80% of women with 1 dysmenorrhea, depending on the medication prescribed.

6) Evidence points to combined use of new anti-prostaglandins (diflunisal) and smooth muscle relaxants (nifedipine in short term use) to relieve the severity of symptoms not relieved by anti-prostaglandins alone.

B. Dysmenorrhea and Arginine Vasopressin

The newest link of research deals with the implication of arginine vasopressin (AVP) as another possible integrated factor in the etiology of primary dysmenorrhea. AVP has been shown to be elevated in women with dysmenorrhea, but how AVP integrates into the sequence of events surrounding painful uterine contractions was unknown. Pieces to the puzzle were known as follows:[16]

1) AVP was raised significantly in women with primary dysmenorrhea.

2) AVP and PGs are both known specific myometrial agonists, which cause contraction.

3) AVP and PGs are known to act synergistically upon the uterus.

4) AVP may activate the uterus through prostaglandin synthesis and release.

5) In women who were treated with nonsteroidal anti-inflammatory drugs and became symptom free, AVP levels still remained elevated.

6) The exact mechanism is still incomplete, but what is felt at this time is that AVP is significantly elevated over baseline levels in dysmenorrhic women. AVP is known to act directly on the myometrium (A) and if potentiated by prostaglandins (B), the result is pain and ischemia. If NSAIDs are administered, then prostaglandin synthesis (C) is deactivated, AVP remains electaed and there is no resulting pain or ischemia.[16] (Figure 1).

As in any theory, there are pitfalls and unexplained questions. First, prostaglandins have been implicated, yet the relative quantity and duration related to the clinical picture at all levels of presentation (mild/moderate/severe dysmenorrhea) have yet to be explained. Second, why are some women affected even though they are probably anovulatory, suggesting an alternate mechanism (i.e., psychogenic component or PGs)? Third, what are the roles and regulation of the other prostaglandins that are produced, (i.e., PGI_2 and thromboxane) and how do they fit in to the pathophysiology? Fourth, how significant is the psychogenic aspect of dysmenorrhea, (i.e., in women with no demonstrable increase in prostaglandin concentration or uterine contractile pressure). Fifth, what is the physiological basis for the increase in prostaglandins during menstruation, or is it natural for some to have high endogenous levels? Sixth, specific studies demonstrating the ability of AVP to produce the same symptoms in normal controls still need to be shown. Seventh, to prove how and why prostaglandins integrate with AVP in the pathophysiology of uterine ischemia. Eighth and last, to study the effect of inhibitors of oxytocin and vasopressin on dysmenorrheic women.[4,16]

Treatment

The two main modes of therapy available for the clinician today are oral contraceptives (OC) and nonsteroidal anti-inflammatory drugs (NSAIDs). Each has separate indications for use. It is recommended that when relief is not found in 6 to 12 months that causes of secondary dysmenorrhea be ruled out.

A. Oral Contraceptives (OC)

Oral contraceptives have been shown to be quite effective in all groups of women with dysmenorrhea, significantly reducing symptoms in 80% to 98% of the population. The ovulatory suppressive nature of OC is well known and indeed these women are anovulatory, but it is not felt that this is the mechanism involved. Primarily, the endometrium becomes hypoproliferative (decidua-like) which decreases the ability of the uterus to produce prostaglandins causing: 1) a reduction in menstrual flow, and 2) a reduction in menstrual discomfort. This has not been proven as of this writing.

The use of the pill in dysmenorrhea is recommended in women who are: 1) young, 2) sexually active and who seek contraception, and 3) relief of symptoms related to dysmenorrhea where secondary dysmenorrhea and premenstrual tension syndrome has been ruled out. If the woman has known contraindication of OC, then the recommendation is the use of the next category, nonsteroidal anti-inflammatory drugs.

B. Nonsteroidal Anti-inflammatory Drugs (NSAIDs)[1,3]

Nonsteroidal anti-inflammatory drugs have come to surface as the mainstay of therapy for dysmenorrhea. It has been known since the early 1970s that the major effect is that they inhibit cyclo-oxygenase, an enzyme in the prostaglandins microsomal endoperoxide synthesis system which inhibits the synthesis of arachidonic acid to $PGG_2\alpha$ endoperoxide in the PG cascade. There has been extensive research in this area and numerous studies can be found for each drug.[1] The known NSAIDs are listed in Table I.

TABLE 1

Prostaglandin Inhibitors	
Indicated for analgesia and dysmenorrhea	Not indicated for analgesia and dysmenorrhea due to side effects
Aspirin	Phenylbutazone (Butozolidin)
Ibuprofen (Motrin)	Oxyphenybutazone (Tandearil)
Mefanamic Acid (Ponstel)	Indomethacin (Indocin)
Naproxen (Naprosyn)	Tolmetin sodium (Tolectin)
Zomepiric sodium (Zomax)	Fenoprofen (Nalfon)
	Sulindac (Clinoril)

Table II lists the essential information for the wide range of medications available for the physician. Each have the common ability of inhibiting prostaglandin synthesis and also have

continued on next page

characteristics unique to each class. Fenamates have been found to be effective in both nonblind and blind trails and also have the ability of inhibiting already made PGs. Ibuprofen has been proven to be effective in both nonblind and blind trails, has minimal side effects, and a rapid onset of action.

Naproxen and Naproxen sodium are the newest drugs extensively studied and reported clinical trails demonstrate a larger success rate with the sodium derivative possibly due to: 1) more rapid absorption, 2) the quickest onset of action (also the quickest of all the drugs), and 3) analgesic properties directly on the myometrium, separate from its PG activity. Aspirin has been found to have the weakest anti-PG activity proven by nonblind and blind trails. Aspirin when given prophylactically was found to be more effective and is the only drug recommended for this type of use. In some circumstances, aspirin is used as the first line of therapy (i.e., adolescence before the stronger anti-PGs are used).

These medications are recommended for use in any woman with primary dysmenorrhea who may or may not wish therapy with oral contraceptives and who does not have a history of peptic ulcer, dyspepsia, hepatic or renal disease, aspirin allergy, asthma, or a bleeding diathesis. At times, short-term use can be permissible with some of the contraindications.

Guidelines for the use of anti-PGs prophylactically are somewhat unclear at this point. It is known that PGs are synthesized premenstrually with rising concentrations culminating at menses, this indicating if anti-PGs were to be used it would maximally suppress the amount of PG made. There is another school of thought that warrants against the use for three reasons: 1) the early pregnancy effects of anti-PGs are unknown at this time, since they are used premenstrually, 2) longer use raises the likelihood of side effects, and 3) due to the irregular menstrual periods of young women, it would be hard to institute correct treatment. In summary, useage would depend upon: 1) age, 2) menstrual regularity, 3) childbearing status, 4) medical history, and 5) susceptibility to side effects.

Summary

Primary dysmenorrhea is the most common gynecologic disorder. Proper history and physical exam must be done to rule out secondary dysmenorrhea or premenstrual tension syndrome. It effects over 50% of all female adolescents and up to 70% of all females in general. This, of course, depends on the population studied. It is the leading cause of absenteeism in school and work among the female population.

A strong relationship holds true for prostaglandins and their effect on uterine contractility. This hypothesis has further been proven by the research with antiprostaglandin therapy. It is from this work that anywhere from 61% to 94% of women have experienced relief from their symptoms, thus improving the quality of life for them. It is also recommended that if relief is not found, further investigation for occult pelvic pathology be sought.

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Table II Common Medications used for Primary Dysmenorrhea

Drug	Plasma Peak (hr)	Plasma Half Life (hr)	Recommended Daily Dose	Starting Dose	Relief Rate %	Advantages/Side Effects
Aspirin (Various brands)	2	6	600mg x 4-6	Same	a	A: Must be given prophylactically, less effective than others SE: UGI tract symptoms Drowsiness, tinnitus
Fenamates						
Mefanamic Acid (Ponstel)	2	6	250-500mg x 4	2x	84-99	A: Only drug available to antagonize already synthesized prostaglandins
Flufanamic Acid (Arlef)	2	6	250mg x 4	2x	82-100	SE: Rare to mild vomiting, diarrhea, hematologic toxicity
Ibuprofen (Motrin)	1-3	3	500mg 4-6	2x	61-82	A: Quick onset of relief SE: Nausea, fatigue, headaches
Naproxen (Naprosyn)	2-4	13	250mg x 3-4	2x	61-67	A: Longer duration of any other drug, may have analgesic properties directed on the myometrium
Naproxen sodium (Anaprox)	0.5-2	13	275mg x 4	2x	74-86	A: Same as Naproxen but has the most rapid onset of action of any drug SE: Nausea, vomiting, diarrhea, headache, fatique, dizziness, acne, exathma
Zomepiric sodium (Zomax)	0.5-2	10[c]	100mg x 4-6	Same	b	A: Effective for quick short term analgesic use SE: UGI tract, dizziness, edema, rash

a: various discrepancies, in some studies placebo relief rate was greater over aspirin
b: no literature to support relief rate
c: multiple doses, one dose equalled 6 hour half-life

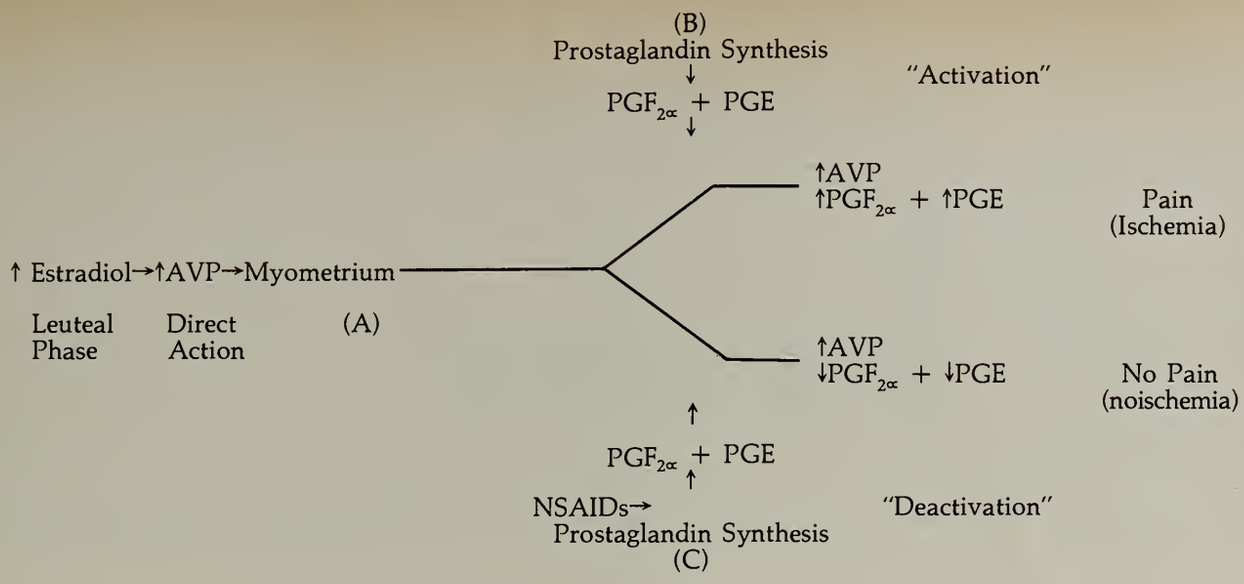
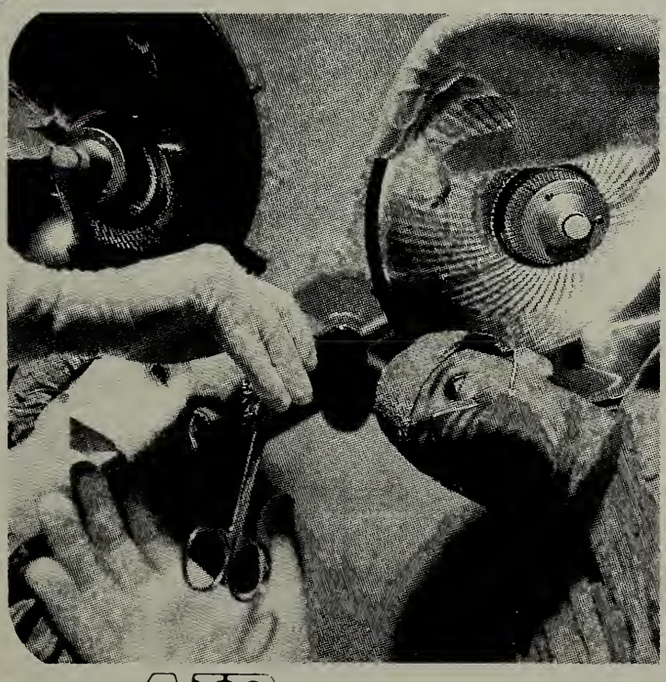


Figure 1: Proposed Interaction of AVP and Prostaglandins in the Genesis of Primary Dysmenorrhea

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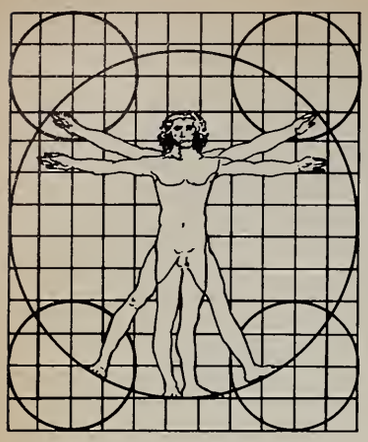
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CLINICAL & SCIENTIFIC

SPLENECTOMY: INDICATIONS, COMPLICATIONS AND MORTALITY

Douglas S. Wagner, MD
Thomas M. Schlueter, MD, FACS

One hundred and twenty consecutive splenectomies over a recent three year period in a large community hospital are reviewed to determine the indications, complications, and mortality associated with splenectomy. The indications for splenectomy have become broader in recent years but the most common indications at this and other hospitals remain trauma, incidental and hematologic. In all large series reviewed, mortality is lowest for splenectomies performed for hematologic indications and highest for incidental and traumatic indications.

INDICATIONS FOR SPLENECTOMY have evolved through the years with more effective non-operative treatment of hematologic diseases, changing approaches to cancer surgery, the concept of staging laparotomies for Hodgkin's Disease, as well as splenectomy for prolongation of survival of transplanted kidneys. The concept of conservation of the spleen when possible, especially in the pediatric age group, is also changing the indications for splenectomy.

A retrospective review to survey the indications, morbidity and mortality for splenectomy at Akron City Hospital in 120 consecutive splenectomies over a recent three year period was done. The most common indications were incidental, traumatic, and hematologic. The overall mortality and morbidity was 14% and 35%, respectively.

Methods and Material

Operative notes and discharge diagnoses for all patients at Akron City Hospital from July 1, 1978 through June 30, 1981 were reviewed and all those cases in which a procedure on the spleen was noted were selected. One hundred twenty-seven charts were so selected. One hundred twenty of the procedures were total splenectomies, two were excisions of accessory spleens, one was a partial splenectomy, and four were suture repairs of the spleen. In order to be able to make accurate comparisons with other studies, only the 120 total splenectomies were considered. In-hospital mortality was used as the mortality statistic. Complications were ascertained by review of the discharge summaries, progress notes, and x-ray reports. Indications for the procedures were determined by review of the patient's hospital record. The 120 splenectomies were performed by 18 attending surgeons.

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Submitted August 5, 1983

Results

Indications for the 120 splenectomies fell into the following categories: traumatized or lacerated spleens from blunt or penetrating injury in 33%; incidental removal of the spleen as a planned portion of a more extensive procedure for benign or malignant disease in 24%; incidental splenectomy secondary to iatrogenic injury or insurmountable technical difficulty in 19%; for primary or secondary hypersplenism in 11%; for staging of Hodgkin's Disease in 7%; for diagnosis in 6%; and other indications in 2% (splenic cyst and wandering spleen).

In-hospital mortality (Figure #1) was 15% (6/39) for patients undergoing splenectomy for traumatic reasons, 16% (8/50) for patients undergoing incidental splenectomy, and 10% (3/30) for the patients with hematologic disease. In more specific categories, 23% (3/13) of hypersplenic patients died, 19% (4/21) of iatrogenic injuries, and 14% (4/28) of elective incidental splenectomies died.

One or more postoperative complications were documented in 35% of the trauma patients, in 43% of the incidental group and in 20% of the hematologic group. Of 36 complications in 27 patients, excluding the trauma patients who often had multiple injuries, the most common problems were: local infections (wound and subphrenic), 14; pulmonary complications, 9; and bleeding, 5. Other less common, but repeated complications included myocardial infarction, sepsis, and multi-system organ failure.

Morbidity and mortality in relation to age of patient was calculated for each of the three categories: trauma, incidental, and hematologic. The results are tabulated in Table #2. An increasing morbidity and mortality is evident for all categories in the over 60 age group, except for trauma deaths.

Comment

Indications for splenectomy have been long established. This includes splenectomy for traumatic injury, iatrogenic injury, and primary and secondary hypersplenism. Indications of more recent acceptance include staging procedures for Hodgkin's Disease, in Hairy Cell Leukemia for relief of massive splenomegaly and prolongation of survival, in pre-renal transplant patients coupled with nephrectomy for decreased immune competence and radical cancer surgery procedures which often demand splenectomy. (Table #3)

Table 1
Indications, Mortality and Morbidity for 120 Splenectomies

Indications	Number	Percent	Mortality		Morbidity	
Trauma	39	33%	6/39	15%	14/39	36%
Incidental	50	42%	8/50	16%	21/49	43%
Mishap	21	17.5%	4/21	19%	10/21	48%
Planned	29	24%	4/28	14%	11/28	39%
Hematologic	29	24%	3/30	10%	6/30	20%
Hypersplenic	13	10.8%	3/13			
Hodgkin's	8	6.6%	0/8			
Diagnosis	7	5.8%	0/7			
Hairy Cell	1	.8%	0/1			
Other	2	1.5%	0		0	
Total	120	100%	17/120	14%	41/120	34%

Table 2
Mortality and Morbidity in Relationship to Age of Patient

	#	# Mortality	%	#Morbidity	%
Trauma					
Age ⩾ 60	7	1	14%	3	42%
Age ⩽ 59	32	5	16%	11	34%
Hematologic					
Age ⩾ 60	11	2	18%	4	36%
Age ⩽ 59	18	1	5%	2	11%
Incidental					
Age ⩾ 60	21	5	24%	12	57%
Age ⩽ 59	29	3	10%	11	38%
Overall					
Age ⩾ 60	39	8	21%	19	49%
Age ⩽ 59	79	9	11%	24	30%

Table 3
Indications

	Hematologic	Trauma	Incidental
Fabri	61%	10%	29%
Traetow	57%	14%	20%
Hodam	39%	10%	51%
McKinnon	40%	15%	40%
Akron City	24%	33%	41%

Recently, trends towards splenic conservation in splenic injury have become prominent, but are not evident in this review. In only one instance over the three-year period was a partial splenectomy performed for salvage, this after an iatrogenic injury. Four repairs of splenic injuries with sutures and hemostatic agents were successfully attempted in the three-year period.

Interest in the role of the spleen in protection against overwhelming sepsis has resulted in the majority receiving pneumococcal vaccine postoperatively.

There were three cases of postoperative sepsis, all fatal, in the immediate postoperative period. Two occurred in patients undergoing radical cancer operations who died of multi-system organ failure. The other mortality occurred in a patient with immune thrombocytopenic purpura on high dose steroids.

In Fabri's[1] study of 1944 splenectomies over 25 years at Ohio State University Hospitals, 61% were performed for hematologic indications including primary and secondary hypersplenism, Hodgkin's staging, and diagnosis of lymphoma. This large proportion of hematologic disease reflects the role of that institution as a leading center for hematology. Twenty-nine percent of the splenectomies were incidental and 10% were as a result of blunt or penetrating trauma. In Traetow's[2] study of 473 additional splenectomies at Ohio State University from 1973-1978, it was found that substantially more splenectomies were being performed for lymphoma staging (4% from 1948-1973 and 27% from 1973-1978). Somewhat fewer were performed for hypersplenism which is attributed to increasing numbers of competent hematologists in outlying hospitals. Splenectomy for trauma accounted for 14% of the cases in the more recent time period, attributed to increasing numbers of auto accidents. In Hodam's[3] 18-year survey of 310 splenectomies at the University of Oregon, 30% of the splenectomies were done for hematologic reasons, 23% for iatrogenic injury, 10% for trauma, and 28% for other reasons. In a series from Tulane, reported by McKinnon et al,[4] of 406 splenectomies over 12 years, 40% were performed for hematologic indications, 14% for trauma, and 40% incidental.

At Akron City Hospital, the leading indication for splenectomy in the last three years has been trauma of a blunt or penetrating nature, accounting for one-third of the total. This is double to triple the rate of traumatic surgery in other series, reflecting Akron City Hospital as a trauma center. Seventeen percent of splenic ruptures in this series were classified as delayed, with rupture occurring one to seven days post-trauma. Some of these cases possibly were actually delayed recognition of splenic rupture. In Fabri's[1] series, 20% of traumatic rupture was classified as delayed.

Twenty four percent of splenectomies at Akron City Hospital are for hematologic indications. Seventeen and one-half percent of the cases at Akron City Hospital were due to iatrogenic injury and 24% planned incidental to other procedures. The iatrogenic injury figure compares to Hodam's[3] 23% and Traetow's[2] "greater than 14%" figure. Of the 29 incidental splenectomies performed with other procedures (Table #4), 11 were

continued on next page

pre-renal transplant situations in which the splenectomy was performed with bilateral nephrectomy. Twelve of the planned splenectomies were performed during radical cancer operations (Table #5), usually for tumors in the left upper quadrant. Of the iatrogenic injuries, two thirds were in the course of gastric surgery (Table #6). The breakdown of hematologic indications for splenectomy are detailed in Table #7.

Mortality figures in all series demonstrate lowest mortality for hematologic disease and highest mortality for trauma (Table #8). Trauma mortality is similar in all series ranging from 15% to 18%. The majority of trauma victims at Akron City Hospital have associated and often more severe injuries. Death is often in spite of splenectomy and not usually due to splenectomy. In this series, there were seven mortalities in trauma patients, whose average age was 30 years; all had serious concomitant injuries. Mortality for hematologic splenectomies ranges from 2.5% to 10%.

There were three deaths in the hematologic group. One patient with hypersplenism died of disseminated intravascular coagulopathy less than 24 hours after surgery. Another with hypersplenism died of multiple organ system failure after several weeks. The third had ITP and died of sepsis one month after splenectomy. Average age here was 70 years.

Consistently in all series, there is a disturbingly high mortality for incidental splenectomy ranging from 13% to 20%. With this series, the figure is 16%, 14% if planned, and 19% if secondary to iatrogenic injury.

Table 4
Indications For The 50 Incidental Splenectomies

29	Planned
12	Radical Cancer Operations
11	Pre-renal Transplant Splenectomies
3	Splenorenal Shunts
2	Pancreatectomies
1	Ulcer Perforating into Spleen
21	Iatrogenic Injuries

Table 5
12 Radical Cancer Operations

4	Gastrectomies or Esophago-Gastrectomies for Gastric Cancer
2	Esophago-Gastrectomies for Esophageal Cancer
2	Left Radical Nephrectomies for Renal Cell Cancer
1	Whipple Procedure
1	Colectomy for Colon Cancer
1	Retroperitoneal Undifferentiated Cancer
1	Adrenalectomy and Pancreatectomy for Adrenal Cancer

Table 6
Primary Procedure During Which 21 Iatrogenic Injuries Occurred

7	Gastric Staplings
5	Nissen Fundoplications
3	Elective Abdominal Aortic Aneurysm Repairs
1	Exteriorization of Sigmoid Colon
1	Left Colectomy for Cancer
1	Vagotomy and Pyloroplasty
1	Aorto-Femoral Graft
1	Gastrectomy and B-I

Table 7
29 Hematologic Indications

8	Staging Laparotomies for Hodgkin's Disease
7	Idiopathic Thrombocytopenic Purpura
7	Diagnostic (5/7 Positive for Lymphoma)
6	Other Causes Hypersplenism
1	Hairy Cell Leukemia

In the Akron City Hospital series, there were four deaths in those with splenectomy added to another procedure. One 53-year-old with cirrhosis and portal hypertension died 20 days after a distal splenorenal shunt. One 54-year-old with renal failure died of an intraoperative myocardial infarction during a splenectomy and bilateral nephrectomy. Another 25-year-old patient died of unknown causes after a pre-renal transplant splenectomy. One 64-year-old patient died of sepsis 17 days after a radical gastrectomy for cancer.

Four of 21 patients having splenectomy for iatrogenic injury in the course of an abdominal procedure died. Two patients undergoing elective abdominal aortic aneurysmectomy died of myocardial infarctions in the immediate post-operative period. One 82-year-old patient died of a myocardial infarction two days after a vagotomy and pyloroplasty. The final death was in a 78-year-old who died of multisystem organ failure and sepsis after a left hemicolectomy for cancer. All of these patients were poor risks whose deaths may or may not have been related to the performance of a splenectomy. A study by Kassom and Thomas,[5] comparing 76 patients with incidental splenectomy during other abdominal procedures to 130 patients matched for age, sex, diagnosis, and operative procedure, showed 6.6% mortality for the splenectomy group and 2.3% mortality for the control group, but this was not statistically significant. Fabri et al[1] noted a six-fold increase in mortality when splenectomy was added to gastrointestinal surgery.

The mortality for Hodgkin's Disease staging procedures in zero in four of five studies reviewed and 7% (4/59) in McKinnon's[4] study.

Complication rate trends were uniform in all studies reviewed (Table #9). Morbidity is highest for incidental splenectomy, then trauma, lower for hematologic splenectomy, and lowest of all for the sub-group with staging procedure for Hodgkin's Disease.

In the trauma patients, 14 of 29 had significant complications. Those without complications were generally those with isolated splenic rupture or spontaneous rupture; they did quite well, in part at least, because of their youth and antecedent good health. In the multiply injured patients, the complications were often secondary to the multiple associated injuries.

In the non-trauma patients, the most common complications were infectious problems. Subphrenic abscess, wound infection, hematoma, seroma, or wound dehiscence were present in a total of 14 patients. Pulmonary complications including pneumonia and left pleural effusion occurred in nine patients. Hematologic complications including hemorrhage and DIC occurred in five. Numerous other complications including myocardial infarction, multiple system organ failure, urinary tract infection, small bowel obstruction, pulmonary embolism, and gastric atony are difficult to ascribe to splenectomy specifically. Three patients had documented septic episodes. All other series reviewed had similar groups of complications and agree that the addition of splenectomy to any given procedure adds significantly to morbidity.

Subdividing splenectomy into hematologic, traumatic, and incidental groups and comparing mortality and morbidity in patients over 60 years of age to those under 60 demonstrated a clear trend of adverse results in patients over 60 years of age (Table #2). Only in traumatic mortality is the difference not obvious. This finding differs from the experience of Deckinga and Printen[7] from the University of Iowa who found that the outcome for patients over the age of 55 was no different than the results in younger patients. They state that the underlying disease determines mortality in the older age group, not the performance of splenectomy.

Summary

A hospital's particular mixture of cases will depend largely on the number of traumatic and hematologic referrals. Mortality is consistently lowest for hematologic splenectomies and highest for traumatic and incidental splenectomies. Accordingly, a hospital's overall mortality statistics will depend on the proportion

Table 8
Mortality

Series	Trauma	Incidental	Hematologic	Total
Fabri, et al	17.7%	14%	6.5%	10.1 %
Traetow, et al	16%	13%	6%	9.25%
Hodam	18%	20%	2.5%	12.2 %
McKinnon, et al	16.3%	16.3%	4.3%	11.5 %
Present Series	15%	16%	10%	14%

Table 9
Morbidity

Series	Trauma	Incidental	Hematologic	Total
Fabri, et al	29%	44%	17%	39%
Traetow, et al	34%	26%	7%	30%
McKinnon, et al	40%	40%	25%	34%
Daoud, et al				62%
Present Series	36%	43%	20%	34%

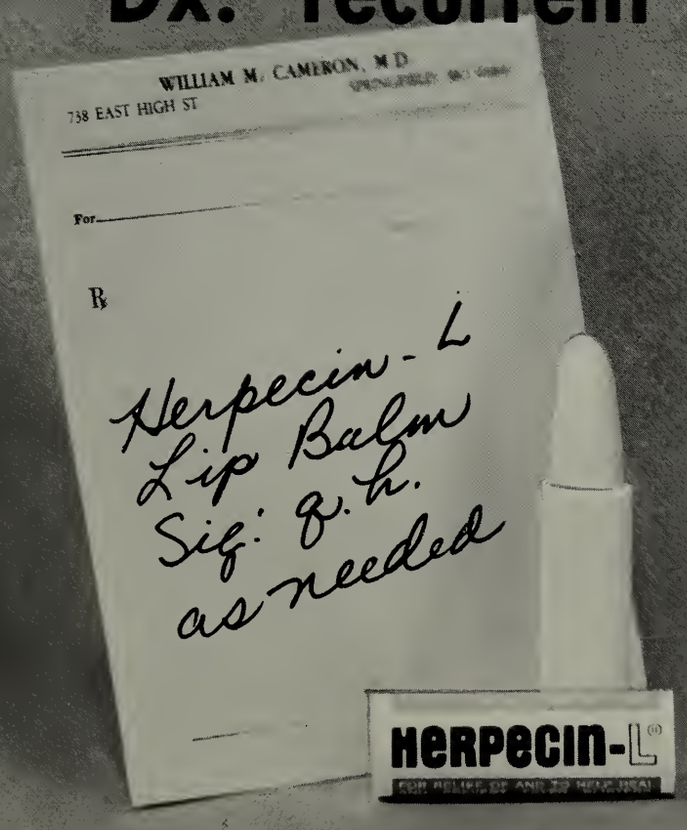
of hematologic and traumatic indications.

There is a trend towards increased morbidity and mortality in patients over 60, compared with younger patients who undergo splenectomies for similar indications.

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Dx: recurrent herpes labialis



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By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

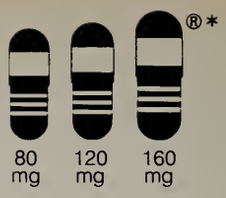
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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

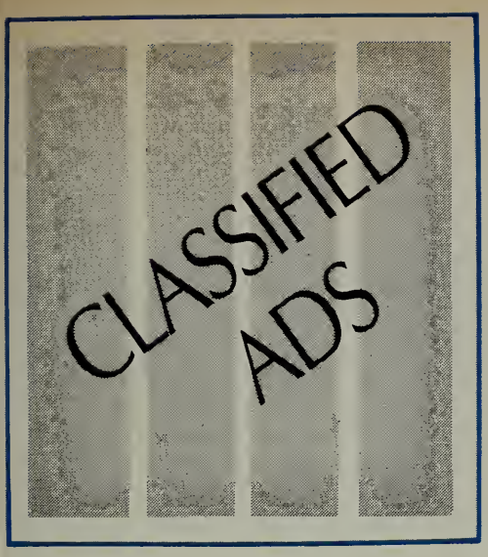
HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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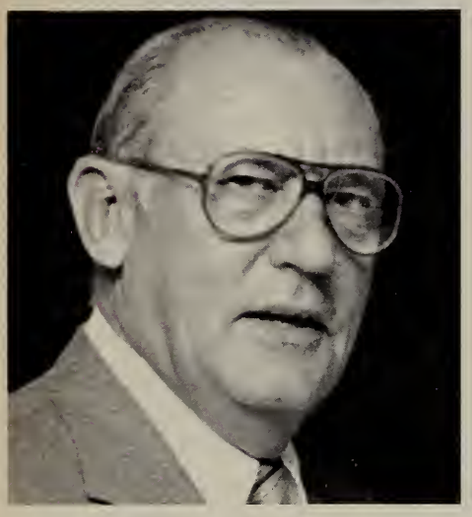
THE Ohio STATE Medical Journal

What Lies Ahead for Ohio's Medical Students?



Colleagues In The News

Edited by Doug Evans



George Schroer, MD

JAMES BARNES, MD, Columbus, has been named a Columbus Medical Bureau Board of Trustees member. He is head of the Neurological Surgery section at Riverside Hospital.

HERBERT S. BELL, MD, Columbus, has been installed as president of the Ohio State Neurological Society. His term runs from May, 1984 through May, 1985.

DUDLEY BRIGGS, MD, Columbus, has been elected to a three-year term on the board of directors of the American Occupational Medical Association, an international organization of physicians who provide health care to workers.

HARRY H. FOX, MD, Cincinnati, has been named the first president of the newly-formed Ohio Dermatological Association. Other officers include: **BENO MICHEL, MD,** Beachwood, President-Elect; and **EDMUND GARDNER, MD,** Columbus, Secretary-Treasurer. Dr. Fox was also elected president of the dermatology section of the Ohio State Medical Association.

WILLIAM D. HOLDEN, MD, Cleveland, was presented the Distinguished Service Award by the American Medical Association at its recent meeting in Chicago.

CHARLES R. HOLZER, MD, Gallipolis, has been named Professor of Surgery at the University of Cincinnati Medical Center effective September 1. Dr. Holzer is chief of staff at the Holzer Medical Center and member of the Holzer Clinic.

ROBERT L. KATZ, MD, Cleveland, has been elected president of the Northeast Ohio Otolaryngology — Head and Neck Surgery Society. Other officers elected include **GREGORY F. O'BRIEN, MD,** Cleveland, secretary-treasurer; and **HARVEY M. TUCKER, MD,** Cleveland, program chairman.

HENRY G. KRUEGER, MD, Cleveland, has been installed as president and chairman of the board of the Cuyahoga County Academy of Medicine. Other officers include **HERMAN MENGER, JR., MD,** Cleveland, president-elect; **DANIEL A. DEUTSCHMAN, MD,** Cleveland, vice president; and **WILMA F. BERGFELD, MD,** Cleveland, secretary-treasurer.

MATTHEW LEVY, MD, Cleveland, has been appointed to the National Board's Part 1 Physiology Test Committee. Dr. Levy, chief of investigative medicine at Mt. Sinai Medical Center in Cleveland, joins the committee responsible for developing the National Board's examinations and assuring the quality and integrity of the evaluation system of the National Board of Medical Examiners.

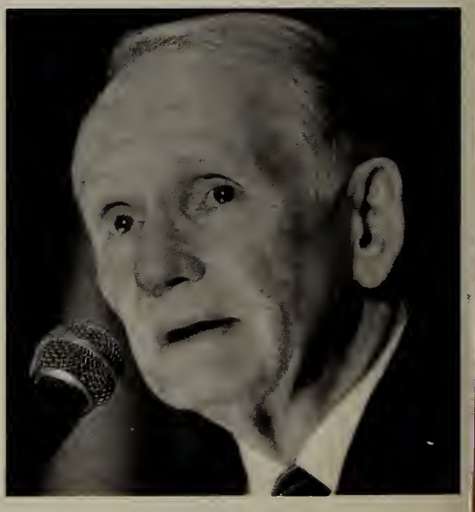
JENNIFER LOGGIE, MD, Cincinnati, and **ROSEMARY SCHMIDT, MD,** Cincinnati, have been elected president and vice president respectively of the Cincinnati Children's Hospital Women's Association. The organization was formed for the women faculty members at the facility.

HERBERT G. MAGENHEIM, MD, Cincinnati, has been elected president of the Cincinnati Jewish Hospital Medical Staff. Also elected to office was **RONALD FEGELMAN, MD,** Cincinnati, as president-elect. Elected to the hospital's medical staff board of directors were **SHELDON FARBER, MD,** West Chester; and **E.D. (TERRY) TRAIFOROS, MD,** Cincinnati. Continuing on the board of directors are **DON LEVI, MD,** Cincinnati; **F. JAY ACH, MD,** Cincinnati; **WALTER MATERN, MD,** Cincinnati; **STANLEY WACKSMAN, MD,** Cincinnati; and **S. MARCUS WIGSER, MD,** Cincinnati.

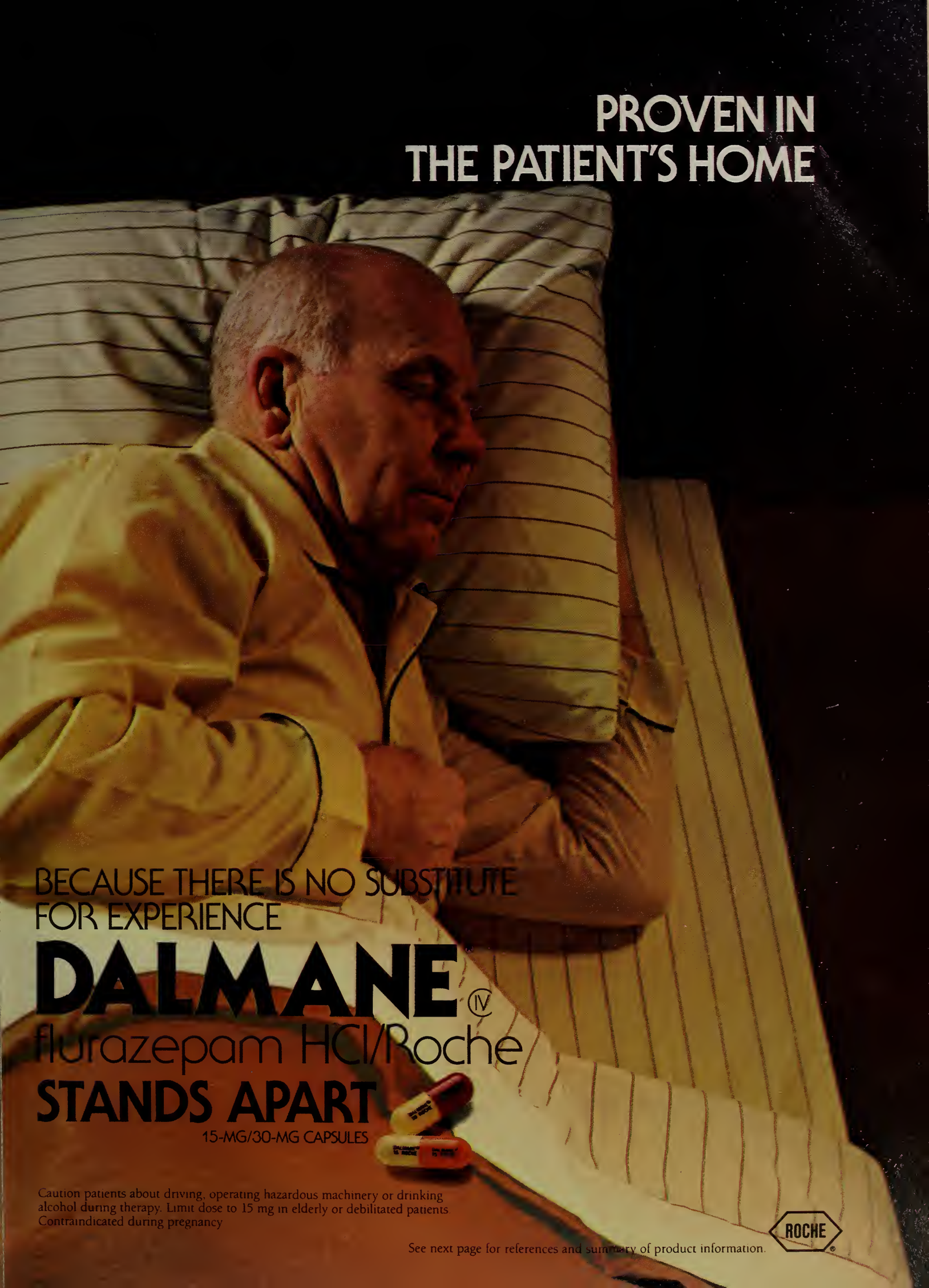
Members of the Second District recently presented **GEORGE SCHROER, MD,** Sidney, with a special plaque for his twenty years of service to the Shelby County Medical Society. Dr. Schroer served many of those years as president.

MARVIN THOMAS, MD, Columbus, has been elected president of the American Society of Clinical Rheumatology.

PAUL ZEIT, MD, Burton, has been elected Chairman of the board of directors of the Emerald Health Network. He is currently director of the Hillcrest Preferred Provider Organization.



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References: 1. Kales J *et al: Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. 2. Kales A *et al: Clin Pharmacol Ther* 18:356-363, Sep 1975. 3. Kales A *et al: Clin Pharmacol Ther* 19:576-583, May 1976. 4. Kales A *et al: Clin Pharmacol Ther* 32:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 6. Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. 7. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 8. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 9. Amrein R *et al: Drugs Exp Clin Res* 9(1):85-99, 1983. 10. Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. 11. Greenblatt DJ *et al: Sleep* 5(Suppl 1):S18-S27, 1982. 12. Kales A *et al: Pharmacology* 26:121-137, 1983.

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Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1983 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

ISSN 0030-1124

THE Ohio STATE Medical Journal

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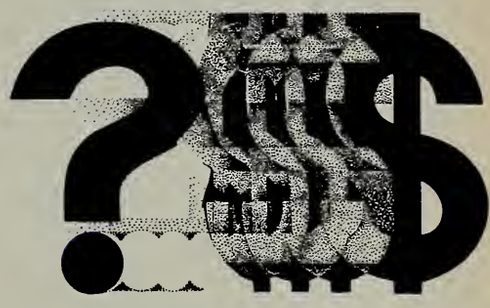
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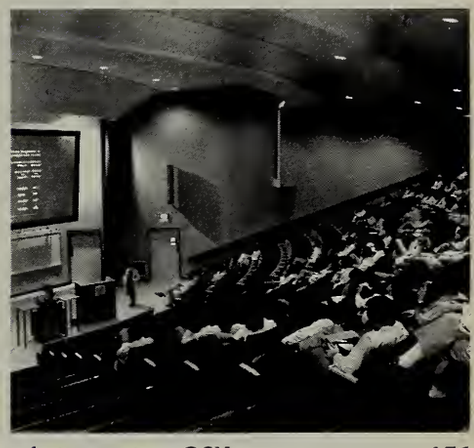


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OUR COVER

Our cover photo, taken by freelance artist-photographer Larry Hamill, features (clockwise from center): Kimberly English, Megan Preston, Grant Gambaiani, Ellen Saslaw and Brian Evans.

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We Need Your Political Clout

By A. Burton Payne, MD

When I was the chairman of the Ohio Medical Political Action Committee (OMPAC), I proudly said that my Ohio colleagues were some of the most politically sophisticated in the country. Imagine my shock when I learned that the AMA has projected that over 30% of the physicians in Ohio are not even REGISTERED TO VOTE! The right to vote in an election is the most basic and cherished of your rights as an American citizen.

In Ohio this year, several programs have been organized to register individuals who receive public assistance and then get them to the polls on election day. Fundamentalist Christian groups also are sponsoring formal voter registration drives in their churches. Across the political spectrum, the goal in 1984 is to register your political supporters and get them to the polls. Medicine cannot afford to have physicians who fail to register or vote. Our professional future is inextricably intertwined with

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political decision makers. To that end, Valerie Vollmer has been appointed to coordinate the Med Vote Campaign in Ohio. The OSMA Auxiliary will be spearheading our registration campaign.

Ohio has one of the easiest voter registration systems in the country. Physicians, their families and their office staffs can add up to political clout. Every vote cast in 1984 will make a critical difference to your future.

If you are not registered, I urge you to do so now. Fill out the voter registration form and mail it — today! Reproduce the form and give a copy to your family members over 18 (by the next election) and your office staff. The form *MUST BE RECEIVED BY THE SECRETARY OF STATE BY OCTOBER 7 — 30 DAYS PRIOR TO THE GENERAL ELECTION NOVEMBER 6, 1984.*

Now that you're registered to vote, you need to help the OSMA help you. The Ohio Medical Political Action Committee (OMPAC) is the OSMA's PAC. It is registered with the Federal Election Commission and the Ohio Secretary of State. OMPAC's purpose is to collect voluntary contributions from OSMA members and their families and to then make contributions to AMPAC and political candidates in Ohio.

OMPAC does not lobby — the OSMA Department of State Legislation does that for you in Columbus, and the OSMA and the AMA lobby the Congress in Washington, D.C. OMPAC evaluates candidates and campaigns and provides financial assistance to those who listen to and support the views of your Association. OMPAC is the only statewide physicians' political action committee. It gets contributions from general practitioners and specialists, from anesthesiology to urology.

OMPAC needs your support today. If you or your spouse haven't joined yet, it's not too late. Complete the form below and mail it to OMPAC, P.O. Box 21117, Columbus, Ohio 43221. Your check today will make a difference in OMPAC's ability to effectively counter the contributions of others.

Politics is a system of money, influence, and votes. Individually, without votes or money, you have little political influence. With all three, you can effectively participate in the system.

On the right are the OMPAC Board members. Each of these physicians and auxilians represents your interests when the OMPAC Board meets. Please feel free to contact them if you have questions about OMPAC.*

**OMPAC is composed of OSMA members and auxilians.*

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Ohio's Medical Students

Medicine's Future in the Making

Never, it seems, has medicine's future appeared more grim than it does today. As rising health care costs bring on increased government regulation and industry intervention, the practice of medicine no longer seems to be what it once was. As one of our authors has so eloquently put it . . . it's not fun anymore.

Yet, paradoxically, never has Ohio been as inundated with medical schools and medical students as it has during the past decade. Since 1970, an anticipated physician shortage in Ohio has been, in part, responsible for the increasing number of students in our medical schools. The University of Cincinnati, The Ohio State University, Case Western Reserve University and the Medical College of Ohio at Toledo, responding to this expected shortage, gradually expanded their class size to aggregate admissions of 750 students. Two new allopathic medical schools have been authorized during this time — Wright State University in Dayton, and Northeastern Ohio Universities College of Medicine in Rootstown — as well as a new osteopathic medical school at Ohio University in Athens.

Whether or not these schools are populating the state with too many physicians is an issue that was explored in-depth last month, and is not really the question here.

This month, we intend to take a look at how medicine's future is shaping up — through Ohio's medical schools and, more specifically, its medical students.

We begin with a study of the medical schools themselves . . . their curricula, their programs, and the types of students who attend. How much has changed in the past five, ten, twenty years?

Then we turn to the medical students for a look at the people who are currently entering the profession. In an age of regulated medicine and increased competition, what motivated them to consider health care as a career? What are their goals, their dreams? What do they think waits ahead for them as tomorrow's practitioners?

In an age of regulated medicine and increased competition, what motivates medical students to consider health care as a career?

Certainly, the issue of costs cannot be ignored. The price tag attached to a medical education, now, has reached astronomical limits. Why? Does it differ from school to school? How are students funding their education?

The answers to all of these questions lie within these pages. Look, too, for some other pertinent information. A view of how medical students affect physician manpower in Ohio is included in a study by Alvin E. Rodin, MD, and Ronald J. Markert, PhD, of Wright State University. Their study investigates change during medical school . . . how and why medical students are switching specialties, often in the middle of their educational careers, and what effect it is having on physician supply.

William Todia, a student from the Medical College of Ohio at Toledo, has sent us a report of the AMA's medical student section meeting that took place in Chicago earlier this summer.

And this month's "Essay" features a poignant look at "Our Future in Medicine" by Nancy J. Cossler, MD, a recent graduate of the Northeastern Ohio Universities College of Medicine.

Is there hope, then, for the practice of medicine? That's what this issue has attempted to answer, and by profiling Ohio's medical schools and its students, we've tried to provide you, the reader, with a view of medicine's future in the making.

Medicine may not be fun, anymore, for some, but at least all factors seem to indicate that its future is secure in Ohio. — *Karen S. Edwards*

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Letters to the Editor

Judge physicians by care, not income

To the Editor:

I appreciated Dr. Saxbe's article, "For Whose Benefit," in the May 1984 *OSMA Journal*. I have become increasingly concerned about the tendency in some medical circles to equate the value of a physician with the amount of income he/she generates. There are some medical group business managers who single out "low producers" in their groups and chastise them for spending too much time with their patients and not generating enough income. Of course, these "low producers" are usually physicians in primary care and non-procedural specialties. A family physician cannot generate as much income as a surgical specialist, no matter how hard he/she works or how much a business manager pushes that family physician.

I hope we do not lose sight of the real value of a physician, namely, his/her ability to give excellent, empathetic medical care to patients. Certainly, each of us needs to generate enough income to pay office overhead, family and home expenses, and to save money for rainy days and retirement. When we have generated that much income, we don't need to apologize to anyone if we do not generate more. We certainly don't need to let our business managers make us feel guilty or inferior if we abide by the AMA voluntary fee freeze, decrease our charges to low income patients, and spend adequate time with our patients, and, just as important, with our families.

I hope we can return to the determination of the value of a physician by quality of medical care, not by income level. This would certainly please our patients, and we would be more comfortable in our practices if our self-esteem and self-worth were based on quality medical care rather than the number of dollars generated.

Sincerely,
Janet K. Bixel, MD
Columbus, Ohio

WANT TO EXPRESS AN OPINION?

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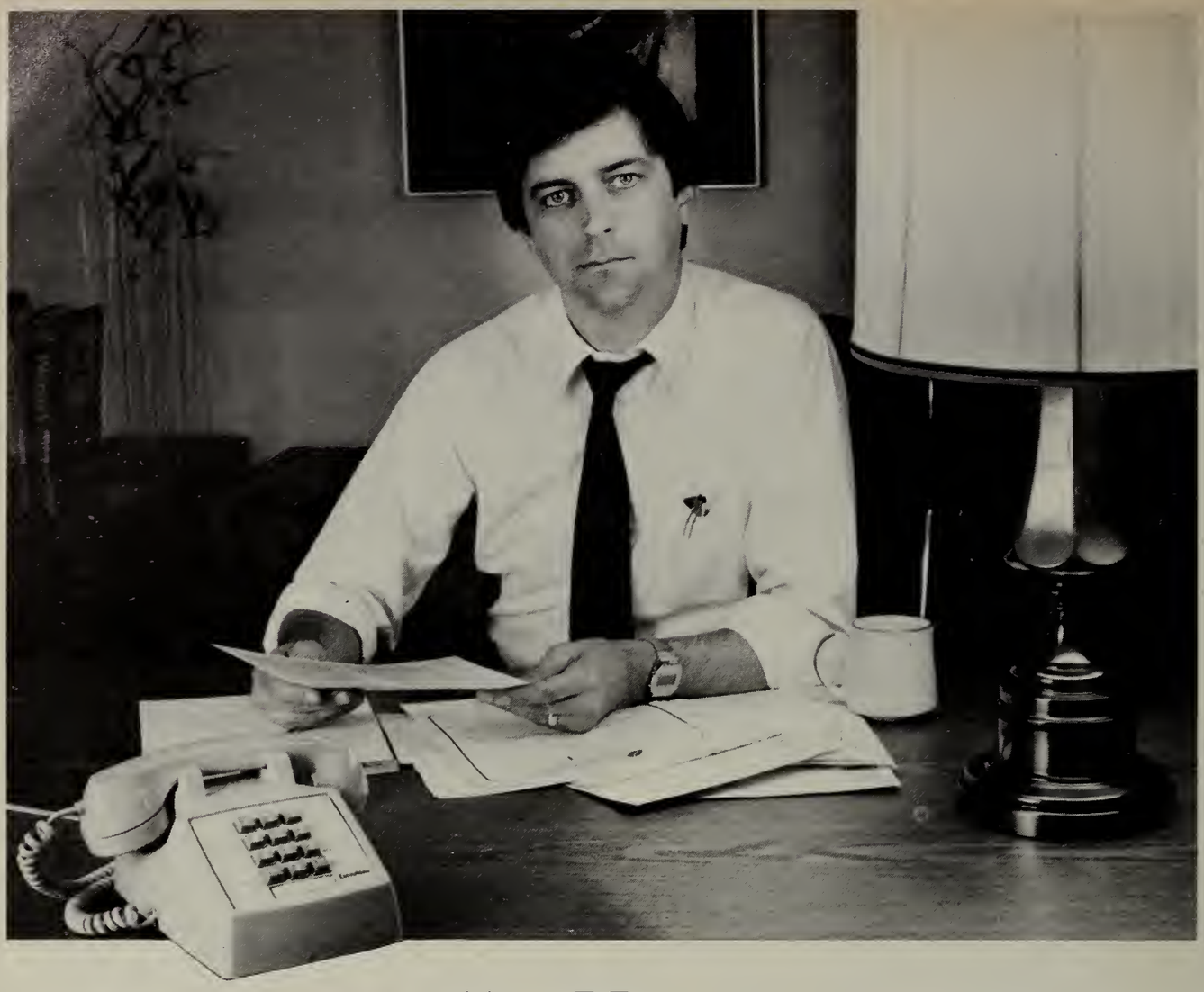
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It's Not Fun Anymore

By Harold G. Kelso, Jr., MD

Editor's Note: *Reprinted with the permission of* **Dayton Medicine** *and the author.*

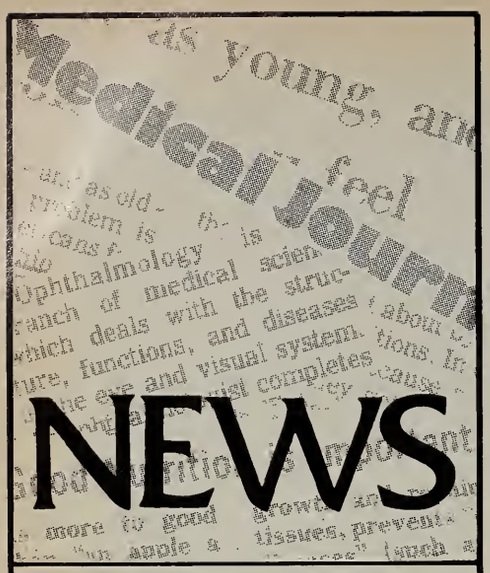
"It's not fun anymore!" Burn-out? Or a realistic appraisal of practicing medicine today? How many times have I heard this statement in the past five years? At the chart rack, the record room, or the lounge over a cup of coffee. I'm sure that many of our colleagues who have opted for early retirement have done so because of the title of this article. Why would anyone quit so early, or give up a career that was so gratifying when they started out?

I asked myself recently when I was forced to focus on this question more closely than I had for a long time. On that occasion a close friend of mine had asked if he could bring his nephew to my house on a rare Sunday afternoon off. As we sat by the blazing fire with the February snows piled high outside, I suddenly felt no enthusiasm for the subject at hand. Where was the zest and vigor with which I used to sing the praises of my profession at career days at the high school? Where was the wisdom and advice that I used to share with young patients interested in medicine, who came to me after hours and sat with me as I extolled the virtues of my profession. Many of these young men and women are now practicing medicine in the community and elsewhere, and I am very proud of whatever part I may have played in their decision. But suddenly here I was with this young man who had the same enthusiasm and excitement as his predecessors, asking me the same questions, and I found myself hesitating and qualifying every answer. Finally, all the doubts and fears I have for the future of medicine became so apparent. I found myself unable to say, "A career in medicine is worth all the sacrifice of youth and family that it takes." It's demanding and all-consuming to obtain the degree and it is a demanding mistress after the degree is obtained. It takes time away from family responsibilities and the enjoyment of spending time with one's children. Medicine requires continuous availability when building a practice, and even more if one is fortunate to build a successful practice. Why was it worth it? It was worth it because of the chemistry that exists between patient and doctor. The non-questioning faith that the patient placed in your hands. That physician-patient relationship that was so simple. The patient presented you with his problems, you diagnosed and treated him, and he rewarded your efforts by paying your bill according to his ability to do so. Now government, unions, employers and insurance companies have stepped between doctor and patient. In ever so many ways, subtle and blatant, these groups have manipulated the patient-doctor relationship.

Last week I saw a hernia as big as a fist, on examination, referred the patient to a surgeon of his own choice, and yet he asked for a second opinion because his insurance company required it. At the office, daily inquiries come from companies requesting dates the patient was last seen for various illnesses, adding to the burgeoning paperwork of the physician. On to the hospital where one has to do a juggling act to get the DRG diagnosis not necessarily in the appropriate medical order but one that will be economically best for government and institution. Then the final insult of signing the face sheet of the chart below the government-required stamp, attesting that you are neither a liar or a cheat, under penalty of the law. Pick up a phone and request permission of the state to admit a Medicaid patient that they are

continued on page 689

For those of us who remember the freedom to treat and the mutual respect between physician and patient, it will be difficult to see patients looking to their congressmen for their health care needs, and for us to be looking to PPOs, the government, and other institutions for our remuneration.



a compilation of the latest developments, reports and products of interest to physicians.

edited by Susan Porter

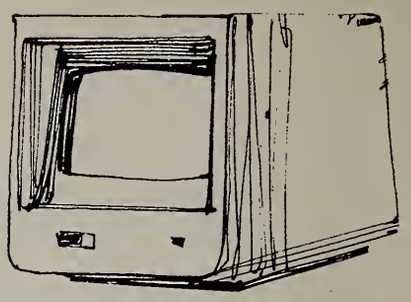
Watched any good journals lately?

First, it was video music . . . now, along comes the video medical journal.

First Image, "The Video Journal of Medicine," makes its debut this month — after two years of study and development — as the first electronic publication in the area of obstetrics and gynecology.

According to editor-in-chief, Stuart Silverberg, MD, and publishers Frye Adamson Marosits, Inc., of Denver, Colorado, each hour-long video cassette issue will carry in-depth coverage of new techniques in clinical practice; round table discussions with preeminent practitioners in Ob/Gyn; coverage of important meetings and seminars; and updates on new technologies. The premiere issue, for example, will feature stories on in vitro fertilization, embryo transfer, as well as coverage of the 40th Annual Meeting of the American Fertility Society. Upcoming topics include: gynecological microsurgery, new developments in contraceptive technology, colposcopy and other current topics.

Executive producer Larry Baker points out that the journal will not attempt to replace print journals. "Indeed," he says, "it can enhance



print, and actually take up where print journals leave off by providing a forum for the exchange of visually documented information which is recorded on film, videotape or slides."

Interaction with subscribers will be encouraged. An evaluation and subscriber response card will accompany each issue and subscribers will be entitled to tie in to the *First Image* computer link for information exchange. In addition, the journal will periodically feature a "Case of the Month" segment which will enable subscribers to present material on unique cases or procedures.

Charter subscriptions for the electronic journal are available through: Frye Adamson Marosits, Inc., 5500 South Syracuse Circle, Englewood, Colorado 80111.

Bears help babies

"Breathing" teddy bears placed in cribs may help premature infants develop more regular breathing patterns, according to a professor of biobehavioral sciences at the University of Connecticut.

For the past 18 months, Evelyn Thoman has been experimenting with stuffed blue teddy bears that "breathe" with a pump-driven air hose insertion. The bears were then placed in the cribs of premature infants, who



generally discovered them within a few days.

The infants then attempted contact with the bears. Once aware of the bears' rhythmic breathing patterns, the infants also began to breathe more regularly, Thoman discovered.

In a second phase of testing, Thoman plans to compare 10 infants with "breathing" bears to 10 with plain bears and another 10 without bears.

Hospitals lose round one in DRG battle

Hospitals in Zanesville, Urbana, Gallipolis, Cambridge, Sandusky, Sidney, Defiance, Logan, Marion and Ashland counties have lost a first-round battle in a court fight over the new Medicare payment system, which they contend discriminates against hospitals outside metropolitan areas.

In a recent ruling in Columbus, however, Federal Magistrate Norah McCann King ruled that the U.S. Department of Health and Human Services (HHS) will not have to produce documents that justify a change in Medicare payments, stating that producing such documents is unnecessary until the court decides whether to dismiss the suit filed by the hospitals.

According to the suit, Medicare's use of the Standard Metropolitan Statistical Area (SMSA) to determine whether or not a hospital is urban, and therefore entitled to higher payments, is inaccurate, because the SMSA is an indication of population density rather than of economic conditions. The hospitals add that the new payment system will ultimately reduce the quality of health care.

Attorneys for HHS have said the suit does not belong in court, because the hospitals have not exhausted their chances to seek changes from the department's Provider Reimbursement Review Board.

Physicians should help prevent child abuse

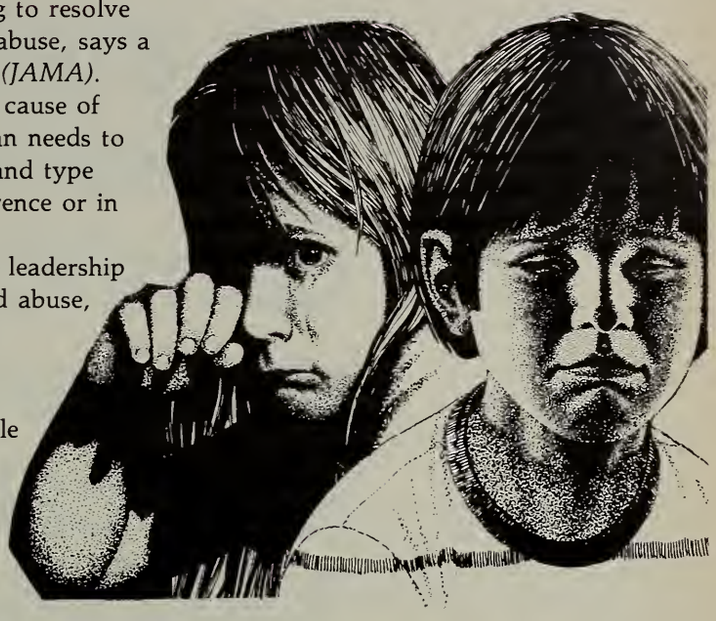
Physicians should take an active role in investigating and trying to resolve problems of domestic abuse, particularly those that lead to child abuse, says a recent article in the *Journal of the American Medical Association (JAMA).*

Noting that child abuse by parents or guardians is a significant cause of childhood disability and death, the author suggests: "The physician needs to have a high level of suspicion in instances . . . where the degree and type of injury is at variance with the history given regarding its occurrence or in any child who dies suddenly."

Medical schools along with organized medicine need to provide leadership in helping physicians to recognize, treat and prevent cases of child abuse, says a *JAMA* editorial on the subject.

Most cases of child abuse occur in children ages three years or younger, the article states.

In addition, hospital emergency rooms should take an active role in identifying cases of domestic violence and provide a crisis intervention plan, according to researchers at the Henry Ford Hospital in Detroit. "Since child and spouse abuse often occur in the same family, all parents of child abuse victims should be interviewed for existence of spouse abuse in the home and vice versa," they conclude.



Six physicians receive awards

Six physicians were recipients of this year's "Ohio Outstanding Team Physician Awards," presented this past summer in Canton, Ohio. The awards are presented jointly by the Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association, and the Ohio High School Athletic Associations to physicians who have:

- provided at least 20 years of service as a team physician for Ohio high schools
- been endorsed by the county medical society, district councilor or osteopathic academy
- been endorsed by school officials, coaches or others.

This year's recipients were: **Theodore R. Ball, MD,** Bellevue; **Robert Culver, DO,** Oregon; **Roland Gandy, Jr., MD,** Toledo; **Asher O. Hoodin, MD,** Deer Park; **Robert L. Kirk, DO,** Smithville; and **William A. Reed, MD,** Burton.

Walk-in clinics not as popular

A recent community attitude survey of Franklin County residents commissioned by the Central Ohio Medical Group revealed that patients still overwhelmingly prefer a long-term relationship with a primary care doctor, despite increasing occasional usage of urgent care centers.

Three hundred Columbus-area residents participated in telephone interviews conducted by Selection Research Center, Inc., of Lincoln, Nebraska. Ninety percent of this group had health insurance coverage provided through an employer.

The results showed that 80% currently have an ongoing relationship with a primary care physician. The average duration of that relationship is 5.76 years. When asked if they preferred to "walk-in" to see a doctor rather than make an appointment, 81% said they did *not.*

However, of the 300 surveyed, over one-third said they had used an urgent care facility of some type. When asked why, 86% mentioned factors relating to time and convenience. (*Location/convenience* was cited by 63%; *no appointment needed* was mentioned by 12%; and *regular doctor not available* was the reason given by 11%.)

The Blues restrict coverage

Beginning sometime next year, the Blue Cross and Blue Shield (BC/BS) Association will begin restricting its coverage of X-rays, CAT scans, and other diagnostic imaging procedures it believes to be medically unnecessary.

The use of diagnostic imaging procedures escalated 8% this year, and is expected to continue to climb. Many procedures are misutilized, overutilized, or redundant, said BC/BS President Bernard R. Tresnowski.

When a procedure is medically necessary and is justified in writing by the physician, the Association will pay for it. When medical necessity is in question, the case will be reviewed by a committee of BC/BS medical advisors. If the doctor and committee disagree, payment will be denied.

"Generally, we will pay the claim. But we'll be asking a lot more questions," said Tresnowski.

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AMA Interim Report

By Oscar W. Clarke, MD and A. Burton Payne, MD

This report covers some of the important issues voted on by the Ohio Delegation at the 1984 Annual Business Meeting of the American Medical Association in Chicago, Illinois, June 17-21, 1984.

There were 73 reports and 182 resolutions considered by the House of Delegates. Four of the resolutions were introduced by the Ohio Delegation to the AMA.

Hospice Care Regulations

The American Medical Association House of Delegates adopted the following substitute resolution regarding Hospice Care Regulations in lieu of the resolution submitted by the Ohio Delegation:

"RESOLVED, That the American Medical Association inform the appropriate governmental agencies of the importance of specifying in hospice regulations that any hospital contracting with a hospice organization for inpatient care should be prepared to offer temporary and limited privileges to the personal physician of the patient while such patient received inpatient hospital care, as long as the normal hospital medical staff credentialing process is followed."

The Ohio Delegation unanimously supported adoption.

Cognitive Services Reimbursement

The second Ohio resolution, Cognitive Services Reimbursement, was combined with four other resolutions on the same subject. The AMA House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association support the concept that third party payors should provide more equitable reimbursement for physicians' services which are solely cognitive in comparison with their procedural services; and be it further

RESOLVED, That the AMA take appropriate action to promote more equitable reimbursement for solely cognitive services with third party payors, business groups and other professional associations; and be it further

RESOLVED, That a report to the House of Delegates be submitted at the 1984 Interim Meeting."

The Ohio Delegation supported adoption.

Payment for Physicians' Services

The third Ohio resolution, Payment for Physicians' Services, was adopted by the AMA House of Delegates. The resolution is listed below:

"RESOLVED, That the American Medical Association encourage third party payors to continue to make available both indemnity and usual, customary and reasonable (UCR) plans so that subscribers may freely choose among various reimbursement methods, including those that incorporate co-payment and deductibles; and be it further

RESOLVED, That the AMA support provisions that give patients the right to assign benefits to their physician under all third party payor plans."

The Ohio Delegation unanimously supported adoption.

Patient and Public Information Program

The fourth Ohio resolution, Patient and Public Information Program, was combined with two other resolutions on the same subject and the following substitute resolution was adopted:

"RESOLVED, That the American Medical Association place emphasis on the continued collection and analysis of information regarding issues of concern to physicians and issues that affect the public's perception of physicians; and be it further

RESOLVED, That such information be widely disseminated to the membership and to the public including joint efforts within the Federation to maximize local involvement."

The Ohio Delegation supported adoption.

Professional Review Organization (PRO) Program

The AMA House of Delegates adopted the Council on Medical Service report on Professional Review Organization (PRO) Programs. The conclusions and recommendations of the report are as follows:

"In light of HCFA's inflexible regulations, as well as the burdensome RFP process which has been imposed on all PRO bidders, the Council is deeply concerned that the PRO program, which was intended to promote the quality of services provided, will develop into a national cost containment effort, which would be unduly disruptive of the relationships between patients, physicians and hospitals and would

interfere with the provision of patient care. Therefore, the Council on Medical Service urges HCFA to allow the PRO program to continue to develop as a program of medical peer review focusing on quality. It is the Council's view that local physician PRO involvement and direction is more critical than ever. In light of these concerns, the Council recommends that the American Medical Association:

1. Reaffirm its support of professionally directed programs of medical peer review if conducted by physician-sponsored organizations and continue to oppose PRO programs by fiscal intermediaries or other third parties;
2. Continue to seek relief from unduly restrictive and inflexible regulations promulgated by HCFA for the PRO program; and
3. Continue to seek various avenues of relief, including the introduction of legislative amendments, and the exploration of judicial action if necessary, to maintain a program of medical peer review, which places the emphasis on quality rather than cost.

The Council and its Subcommittee will continue to monitor closely developments in the implementation of the PRO program and will report further as appropriate."

The Ohio Delegation unanimously supported adoption.

Proposed PRO Sanctions

The AMA House of Delegates adopted the following resolution:

"RESOLVED, That the House of Delegates direct the American Medical Association to take what further action it deems necessary to affect an appropriate change in proposed regulations, published in the *Federal Register* on April 18, 1984, entitled "Imposition of Sanctions on Health Care Practitioners and Providers of Health Care Services," to render them fair, adequate and constitutional."

The Ohio Delegation unanimously supported adoption.

Government Medical Education Loans

The AMA House of Delegates adopted the following amended resolution:

"RESOLVED, That the American Medical Association deplores the lack of integrity and financial responsibility reflected by the actions of a small group of physicians who fail to repay their government loans or fulfill their medical service obligations, and that the AMA encourage the use of appropriate legal methods to see that the obligations are met in a timely fashion; and be it further

RESOLVED, That the AMA continue to support financial assistance programs for medical students to the fullest extent."

The Ohio Delegation unanimously supported adoption.

Postgraduate Training for Foreign Physicians

The AMA House of Delegates referred a resolution, Postgraduate Training for Foreign Physicians, to the Board of Trustees for a report back to the House of Delegates at the 1984 Interim Meeting. The Chairman of the Council on Medical Education informed the Reference Committee that the Council is developing a detailed report on foreign medical graduates, including the subject of this resolution for the 1984 Interim Meeting.

The Ohio Delegation unanimously supported referral.

Medical Staff Bylaws and Medical Staff Self-Government

The AMA House of Delegates adopted an amended Board of Trustees report, Medical Staff Bylaws, as well as a resolution, Medical Staff Self-Government:

Medical Staff Bylaws

"1. That individual hospital medical staffs be encouraged to develop bylaws provisions affirming the binding effect of the bylaw provisions on both the governing body and the medical staff, where consistent with applicable state law; and
2. That AMA Commissioners to the JCAH ask the JCAH to amend its *Accreditation Manual for Hospitals* to provide for mutual adherence to bylaws adopted by the medical staff and approved by the hospital governing board; and
3. That this report be adopted in lieu of Resolution 67 (I-83)."

Medical Staff Self-Government

"RESOLVED, That the American Medical Association go on record that the hospital governing board bylaws not contain provisions whereby the hospital corporate board or administrators could unilaterally amend the medical staff bylaws, or its rules and regulations; and be it further

RESOLVED, That the AMA Commissioners to the Joint Commission on Accreditation of Hospitals be instructed to incorporate this into the Joint Commission on Accreditation of Hospital standards."

The Ohio Delegation unanimously supported adoption.

Joint Commission on Accreditation of Hospitals and JCAH Revisions Inconsistent with AMA Substitute Resolution 45 (I-83) — Admitting Privileges

The AMA House of Delegates filed a Board of Trustees report, Joint Commission on Accreditation of Hospitals and adopted an amended resolution, JCAH Revisions Inconsistent with AMA Substitute Resolution 45 (I-83) — Admitting Privileges. The filed report includes the following statement:

"Individuals granted the privilege to admit patients to inpatient services are members of the medical staff. Individuals are granted the privilege to admit patients to inpatient services in accordance with state law and criteria for standards of medical care established by individual medical staff . . ."

JCAH Revisions Inconsistent with AMA Substitute Resolution 45 (I-83)

"RESOLVED, That the American Medical Association continue to seek to revise the Medical Staff Chapter of

the Joint Commission on Accreditation of Hospitals (JCAH) Accreditation Manual for Hospitals, in accordance with the spirit and intent of Substitute Resolution 45, which, in particular, did not tie the granting of the privilege to admit patients to inpatient services with medical staff membership, Standard I, page 10, C1, line 2 to read as follows:

'Individuals granted the privilege to admit patients to inpatient services may or may not be members of the medical staff'; and be it further

"RESOLVED, That any revisions of JCAH language reaffirm that the Medical Staff retain responsibility for clinical privileges and patient care standards for all practitioners admitting to the facility."

The Ohio Delegation unanimously supported adoption.

Organized Self-Governing Medical Staff and Medical Staff Bylaws

The AMA House of Delegates adopted a Board of Trustees report, Organized Self-Governing Medical Staff, and an amended resolution, Medical Staff Bylaws.

Organized Self-Governing Medical Staff

"The Board of Trustees recommends that the position of the American Medical Association with respect to the responsibilities and functions of the hospital, its governing board, and the medical staff that:

1. The hospital has corporate responsibility for maintaining the necessary facilities, a safe environment, and a mechanism for the prudent selection of those who treat patients within the institution.

2. The governing board is responsible for the operation and management of the hospital and fulfilling its corporate responsibilities.

3. The organized medical staff and its members have a contractual obligation, entered into with the hospital, to carry out their professional medical responsibilities through (a) the efficient operation of medical staff committees; (b) the objective selection of professionally qualified members of the organized medical staff and disciplinary functions relating to their competent performance; and (c) functioning as a self-governing body in promoting quality patient care within the hospital.

4. Members of the organized medical staff may likewise deal collectively, as an entity, with the hospital and its governing board with respect to professional matters involving their own interests, as distinguished from the functions the organized medical staff performs on behalf of the hospital."

Medical Staff Bylaws

"RESOLVED, That the American Medical Association support as policy that 1) the medical staff bylaws, rules and regulations shall be initiated and adopted by the medical staff and shall establish a framework of self-government; 2) the medical staff shall govern itself by these bylaws, rules and regulations which shall: a) be approved by the governing body, whose approval shall not be unreasonably withheld; b) be reviewed and revised as necessary to reflect current medical staff practices; c) define the Executive Committee of the medical staff whose members are selected in accordance with criteria and standards established by the medical staff; and 3) the medical staff shall have authority to approve or disapprove all amendments to medical staff bylaws, rules and regulations; and be it further

RESOLVED, That the AMA direct its Commissioners to the Joint Commission on Accreditation of Hospitals to have these statements incorporated in the Joint Commission on Accreditation of Hospitals Standards."

The Ohio Delegation unanimously supported adoption.

Rights of Committees of Medical Staffs to Meet in Executive Sessions

The AMA House of Delegates adopted the following resolution:

"RESOLVED, That the American Medical Association support the right of any hospital medical staff committee to meet in executive session with only voting members of the medical staff present in order to permit open and free discussion of issues such as peer review, and to maintain confidentiality; and be it further

RESOLVED, That individual medical staffs be encouraged to incorporate provisions to accomplish these objectives into their medical staff bylaws."

The Ohio Delegation unanimously supported adoption.

NCI-Cancer Information Service, NCI List of Physicians with "Expertise" in Cancer Care, and Review Physicians Referral Lists

The AMA House of Delegates referred a Board of Trustees report, NCI-Cancer Information Service, and a resolution, Review Physicians Referral Lists, to the Board of Trustees with a request for a progress report at the 1984 Interim Meeting. The AMA House of Delegates adopted a substitute resolution, NCI List of Physicians with "Expertise" in Cancer Care, as follows:

"RESOLVED, That the American Medical Association voice its opposition to the development by an agency of the federal government of a list of physicians with 'special expertise' in cancer care; and be it further

RESOLVED, That the AMA notify those groups who have lent their names and the developments of the NCI list of the strong AMA policy of being against such lists."

The Ohio Delegation unanimously supported these actions.

Organ Donor/Recipient Clearinghouse (OD/RC)

The AMA House of Delegates adopted a Board of Trustees report, Organ Donor/Recipient Clearinghouse (OD/RC), which responds to a previously referred resolution by reporting on the developments of external initiatives in this field and by citing the AMA efforts to identify related services suitable for the

AMA/NET Network.

The Ohio Delegation unanimously supported adoption.

Protocol for Emergency Services Personnel

The AMA House of Delegates adopted a Board of Trustees report which recommends the following guidelines and principles to govern physician involvement on the scene of a medical emergency, prior to hospitalization when the physician desires to assume complete responsibility for the patient:

Recommendations

"The increasing activity and development of prehospital care in emergency medical services systems have increased those rare instances of contact between EMTs and related allied health emergency care personnel in the field and physicians on the scene of a medical emergency. *The physician on the scene should understand that pre-hospital EMS systems operate under the authority and direction of a licensed physician, who has both medical and legal responsibility for the system.* The scope and extent of these prehospital emergency care programs have increased to such an extent that physicians in the earlier stages of their clinical training should be made familiar with the nature of the shared medical responsibilities inherent in such programs. In promulgating guidelines pertinent to physician involvement on the scene of a medical prehospital emergency, the Board believes that the following general principles should be recognized. The Board notes that these guidelines apply only to those rare instances where a physician happens upon the scene of an emergency *and* the physician desires to take complete medical and legal responsibility for the patient.

1. A reasonable cooperative procedure should be established whereby a physician may assist with and work within the area-wide EMS protocols.
2. It is the obligation of the physician (who happens to be on the scene) to provide reasonable identification.
3. Where voice communication with the medical control facility is available, the EMT and the physician on the scene should both interact with the local medical control authority.
4. Where voice communication is not available, the physician on the scene of an emergency should sign appropriate forms indicating that she/he will take full medical and legal responsibility for the patient(s) — including transportation to the medical facility. Further, medical control systems lacking voice communication capability should consider the addition of such communication linkages to further strengthen their potential in this area.
5. The physician should avoid involvement in resuscitative measures that exceed his or her prior training or experience."

The Ohio Delegation unanimously supported adoption.

Medical Physician Attestation Statement

The AMA House of Delegates adopted a substitute resolution, Medical Physician Attestation Statement, in lieu of twelve other resolutions dealing with the same subject. The substitute resolution is as follows:

"RESOLVED, That the American Medical Association continue its strong and concentrated efforts to seek elimination of the so called 'physician attestation' statement requirement from the Prospective Payment System regulations; and be it further

RESOLVED, That the AMA widely communicate to physicians its efforts toward elimination of the 'physician attestation' statement; and be it further

RESOLVED, That the AMA urge all physicians to communicate promptly with their congressmen and senators, requesting elimination of the 'physician attestation' statement."

The Ohio Delegation unanimously supported adoption.

Prospective Payment to Hospitals

The AMA House of Delegates adopted the following substitute resolution in lieu of six other resolutions on the same subject:

"RESOLVED, That the American Medical Association, through all appropriate channels, seek the regulatory and legislative changes needed to insure that differences in DRG based payment to different categories of hospitals are based on true differences in the costs of providing services by those hospitals, rather than on arbitrary criteria."

The Ohio Delegation unanimously supported adoption.

Development of Prospective Payment to Physicians

The AMA House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association continue its opposition to the expansion of the Prospective Payment System to physicians, and be it further

RESOLVED, That the AMA keep the membership informed regarding current development of any prospective payment system for physicians under Medicare."

The Ohio Delegation unanimously supported adoption.

National Voter Registration Project — Medvote

The AMA House of Delegates adopted a Board of Trustees report which describes a national voter registration drive for the 1984 elections being conducted by the AMA and the AMA Auxiliary.

The Ohio Delegation unanimously supported adoption.

AMA Consultation with Specialty Societies

The AMA House of Delegates adopted the following amended resolution:

"RESOLVED, That the American Medical Association Board of Trustees, councils, committees, and staff continue to seek the help and

advice of appropriate specialty societies, as soon as it is recognized that a topic within the probable area of expertise of a specialty society will be the subject of significant deliberation, action or reports by the AMA."

The Ohio Delegation unanimously supported adoption.

IRS Physician Impersonation

The AMA House of Delegates adopted the following amended resolution:

"RESOLVED, That the American Medical Association study the Internal Revenue Service campaign of physician impersonation and report back to the House of Delegates at the 1984 Interim Meeting."

The Ohio Delegation supported adoption.

Oscar W. Clarke, MD, Gallipolis, is Chairman of the Ohio Delegation to the AMA. A. Burton Payne, MD, Ironton is President of the OSMA and Co-Chairman of the Delegation.

Caretakers to learn how to care for elderly parents, relatives

Lakewood Hospital in Lakewood, Ohio is initiating a new program called "Senior Care" which is aimed at educating caretakers who must manage the health needs of elderly parents or relatives.

The program is comprised of a series of eight weekly classes which offer practical knowledge on communicating with the elderly, dealing with confusion and a review of community resources. Physical care of the elderly will be discussed, highlighting nutrition, bathing and skin care and physical and occupational therapies.

Full AMA Reports Available

There are many excellent reports presented to the House of Delegates at each meeting, covering a wide range of subjects that are of interest to physicians. These reports, prepared by AMA Board of Trustees, council, committees and staff, contain a wealth of information.

A listing, by title, of some of the reports follows. If you would like a copy of any of these reports, please contact the OSMA office.

1. Maternal and Child Health
2. Educational Program About Unscientific Practices in Medicine
3. Rationing of Medical Care
4. Preserving the Physician-Patient Relationship
5. Poison Control Centers: Computer Linkage for the Dissemination of Information
6. State Risk Pooling Model State Legislation
7. Hepatitis B Immunization for High-Risk Personnel
8. Definition of a Bona Fide Emergency
9. Poison Control Centers
10. Life-Sustaining Medical Treatment
11. Corporal Punishment in Schools
12. The Effects of Market Forces on the Supply of Health Manpower
13. Increased Liability Under DRGs
14. Incorporation of Medical Staffs
15. Examinations for Licensure
16. Organ Donation
17. Terminal Illness — Patient's Preference
18. Use of Computers in Medicine
19. Cost-Shifting: A Review of the Issues
20. Status Report on Second Surgical Opinion Programs
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22. Quality of Care

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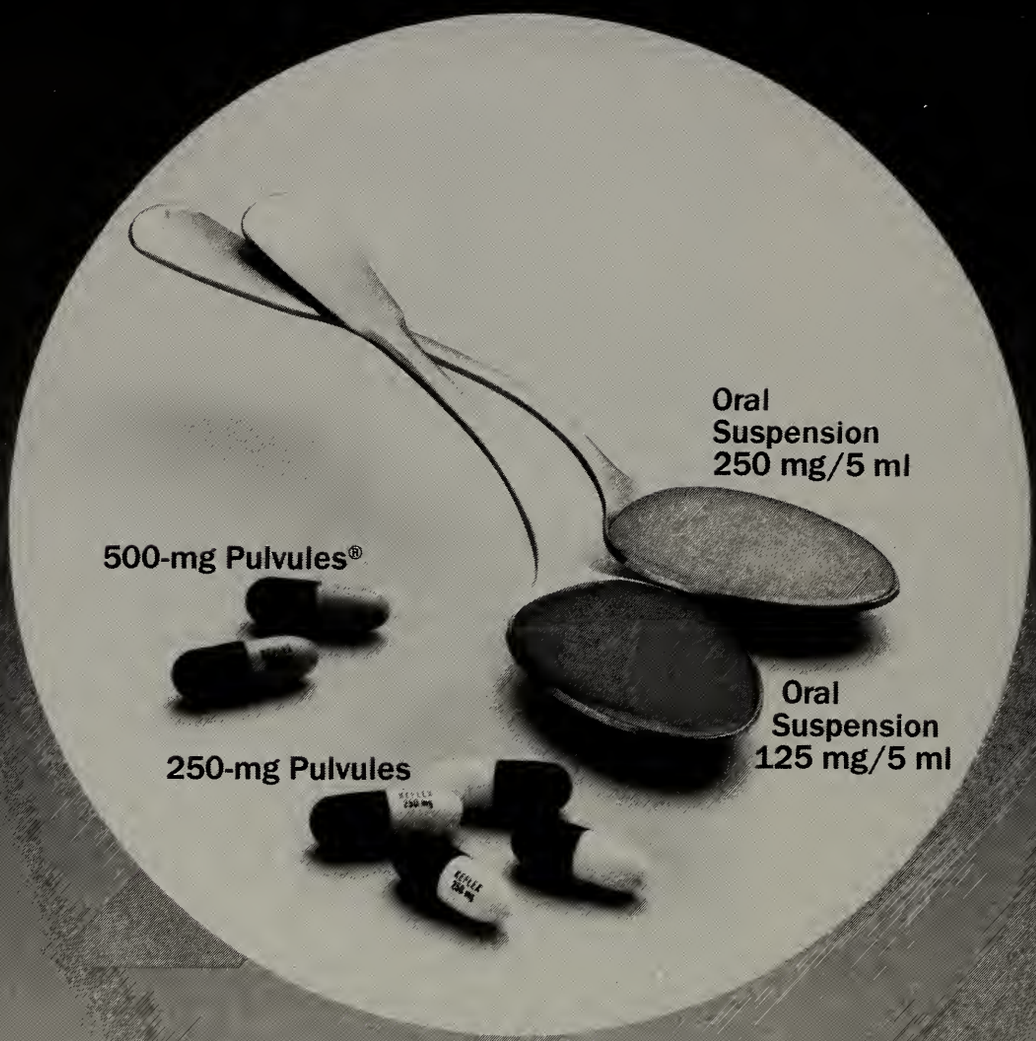
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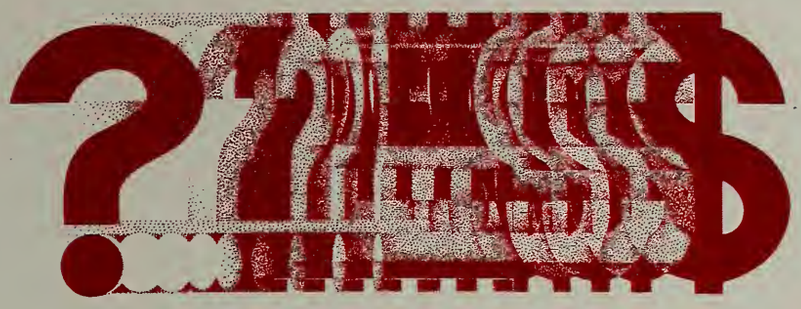
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What the State Found Out About Health Care Costs

By Karen S. Edwards

Between 1970 and 1982, health care spending in Ohio had reached an all-time high. Figures tripled, increasing from $3.8 billion to $14.7 billion — and even now, health care costs continue to represent 10.5% of Ohio's gross national product.

Obviously, something had to be done — some study made that could put forth some concrete recommendations to keep these costs in line, yet still maintain access for Ohio's citizens to a quality health care service. For this reason, the Governor created a special commission to study the problem — and what could be done to correct it.

In a sense, the job was a bit idealistic. The commission, itself, recognized that there are no simple answers to the problem — that no single group and no single action could keep health care costs completely under control. But by tracking the causes of these rising costs, the commission felt some methods could be devised which would control the patterns of escalation and hence the price tag that accompanies them. Unfortunately there were too many variables.

This past July, the Governor's Commission on Ohio Health Care Costs released its final report — a report which offered 23 recommendations designed to "enhance the cost effectiveness of Ohio's public and private health care programs, and to capitalize on the growing competitiveness of the health care industry."

The recommendations of the Commission fell into six basic strategies:

"The work of the Commission has been hindered by a number of factors. However, its most serious flaw is the lack of consumer involvement."

- To improve the cost effectiveness of State-sponsored health care programs
- To achieve greater cost effectiveness in private sector health care programs
- To ensure the availability of meaningful and comparable data that will facilitate active decision-making by health care consumers.
- To reduce excess capacity and increase the availability of services in medically underserved areas.
- To enhance competition by redistributing the cost of uncompensated health care for Ohio's medically indigent and
- To promote physical and mental well-being.

"From the beginning, the Task Force operated on the theory that the market force should rule," says Catherine Costello, J.D., Director of OSMA's Department of State Legislation. "But questions continued to come up during discussions — should there be cost effectiveness at any cost? Should we allow hospitals to close? They were questions that had to be answered."

And some were — but not many, and not as successfully as might have been hoped.

D. Ross Irons, MD, Bellevue, who served as OSMA's representative on the Task Force, voices his disappointments:

"The work of the Commission has been hindered by a number of factors — lack of sufficient knowledge and a breadth of expertise among members, abscence of adequate data and other factual information, special interest intransigence and overriding political objectives. Its most serious flaw, however, is one fundamental omission: its recommendations ignore the most elementary and critical aspect of effective cost containment —

consumer involvement."

The Commission, founded on the principal of market rule, simply — and ironically — chose to ignore the consumer in outlining its strategies.

"The six points outlined in the report, as well as the specific recommendations, lose all meaning — and will ultimately be ineffectual — in the abscence of consumer involvement," Dr. Irons says.

"The Commission was weak on its responsibility to the physician manpower issue, for example," says Costello. "They wouldn't take a stand."

Although the Commission's fourth strategy is to "reduce excess capacity and increase the availability of services in medically underserved areas," its focus seemed to be exclusively on the issue of "too many hospital beds" and not on the issue of physician manpower.

"A more flexible certificate-of-need process and the proposed health care redevelopment corporation might help the state address the problem — but the related cost problem of excess numbers of individual practitioners was not addressed," says Dr. Irons.

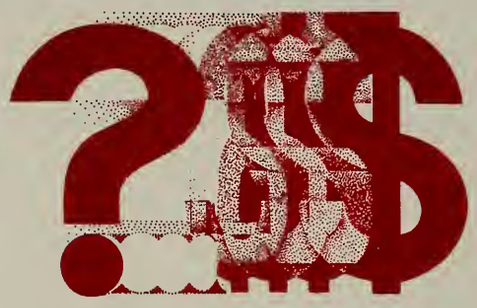
He suggests a three-phased program to address the problem: 1) reduce the number of admissions to Ohio medical schools; 2) implement a program for screening unqualified graduates of foreign medical schools for licensure, and 3) establish an incentive program to locate physicians in medically underserved areas.

"The Commission would have done well to recognize, too, the high costs that go along with the allied and limited health practitioners' demands for mandated hospital privileges and third-party reimbursement," Dr. Irons notes.

Perhaps the one point of the Commission's report that received most attention from the press was the one calling for public disclosure of fees — both by the hospital, and by the physician.

"The OSMA has always encouraged physicians to disclose their fees to their patients, but we feel that the public disclosure of fees is dangerous, and can drive up the costs of health care," says Costello. She explains that the publication of fees will, in effect, serve as a type of "public UCR". "Those physicians who may not be charging much now for their services could raise their rates once they see what their colleagues are charging for the same service."

She argues, too, that it's impossible for a consumer to "comparison shop" because services can vary so much. "A physical exam from one doctor can be a very basic, perfunctory exam — while another doctor may utilize a battery of tests and lab work-ups."



"The Commission explored only superficially the two largest cost items within our health care system — the malpractice environment for medical care, and the expansion of the long-term care industry."

Besides, she adds, comparison shopping negates the whole idea of quality of service.

"You are putting price dictates against quality of care," she says.

Whether or not publication of physician fees ever gets off the ground, Costello is certain of at least one thing.

"I think you will be seeing lots of disclosures of hospital costs going on," she says.

Another strategy which captured a great deal of media attention was strategy #5, "Enhancing Competition by Redistributing the Cost of Uncompensated Health Care for Ohio's Medically Indigent."

"The Commission asked the question, should the expense of indigent patients not picked up by the government be taken care of in a more organized manner?" says Costello. "And in answering that question, they turned to the hospitals."

What resulted in "virtually the eleventh hour" says Costello, was a "Care and Share" program which attempts to make hospitals take the same share of a community's non-paying patients as it does of its paying patients.

"Although the Commission's objective is commendable, the program is insufficient, in my opinion," says Dr. Irons. "It is another form of making the acute and chronically ill shoulder the costs of our medically indigent. The costs of care for the medically indigent should be addressed directly by the state legislature through the biennial budget process and not circuitously through programs like this."

In a recent newspaper article which appeared in the *Columbus Dispatch* concerning the Commission report, John Callendar, vice-president of finance for the Ohio Hospital Association, agreed.

"The patients are not going to be redistributed. What you're talking about in the long run is redistributing money," he was quoted as saying.

The hospital association submitted an alternative plan, but it was rejected by the Commission.

"The Care-and-Share plan would have to have legislative input in order to survive," Costello adds. "It's simply not a self-policing issue. With DRGs and prospective payments to worry about, most hospitals would probably ignore it."

Perhaps the report's most serious fault, however, lies in two areas which were left untouched by the Commission.

"The Commission explored only superficially the two largest cost items within our health care system — the malpractice environment for medical care, and the expansion of the long-term care industry," says Dr. Irons.

Concerning the former, he adds that "the increasingly litigious orientation of our society has resulted in a 'backside' demand for more — not fewer — test procedures. The provider response to medical malpractice threats is the practice of defensive medicine."

As Dr. Irons points out, all available research indicates that defensive medicine accounts for a significant amount of the increase in health care costs. "The medical malpractice environment must be stabilized if costs are to be effectively addressed," he says.

"Perhaps the greatest disappointment in the report," says Costello "was that long-term, chronic care was simply not addressed."

Although arguments have been made that long-term care was not the charge of the Commission, "the group discussed other matters that were not actually in their original charge," Costello claims.

"The point is, the subject of long-term care needs serious thought by the state because it is not going to go away. They currently have no direct strategy for this issue, and consequently, the state is handling it in a patchwork fashion," she says.

"In coming bienniums," Dr. Irons adds, "the medical care savings which might be realized through implementation of the Commission's recommendations will seem insignificant in the face of fantastic expenditure escalation of our long-term care industry."

In a final, overall critique of the report, Dr. Irons adds: "The Commission ignored an elementary, yet critically important, factor in a market approach — consumer involvement in cost considerations. And finally — and unfortunately — the Commission endorsed new forms of health care rationing by endorsing DRGs and calling for the creation of other experimental reimbursement schemes. The political viability of these new programs will continue only until their access and quality consequences are better understood by the public."

The Communications Committee, as well as OSMA's Department of Communications, is already acting on Resolution 29-84, adopted at the Annual Meeting this past May, which calls for a "top priority, public education effort", providing information regarding the effect of social economic and scientific changes in the medical care system. How the public will react or what steps they will take cannot be predicted at this point.

Nor, says Costello, can the legislature be any more predictable.

"We are looking, hopefully, to practical programs coming out of this report, legislatively and in the rules," but she is not anticipating any imminent legislation.

"The Department of Insurance has formed a task force which is looking into the liability problem," she says, and she points out that David Jackson, MD, Director of the Ohio Department of Health, has set up a committee to study long-term care, "so some issues that were not covered in the report are being addressed by the state through other means.

"The Association feels that a great deal of hard work and effort have been put forth by all members of the Commission — and we intend to remain active as the suggestions made in their report come into the legislative process," says Costello. "We want to make sure that the implementation of legislation is done in a manner that is most beneficial to the patient."

And it is that concern that seems to say it all. **OSMA.**

Karen S. Edwards is Executive Editor of the **Ohio State Medical Journal.**

Ohio State Medical Journal Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted *in the original* on standard 22 x 28-cm (8½ x 11-inch) white typing paper.

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(c). Legends for the figures should be written on separate paper.

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6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

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References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

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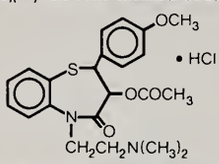
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CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

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The AMA's Medical Student Section Annual Meeting, 1984

By William J. Todia

The Medical Student Section of the American Medical Association met in Chicago, June 15 to 17, 1984. Ohio was represented by: Judith B. Lavrich, Delegate, University of Cincinnati and Secretary of the OSMA-MSS; Joseph Lydon, Delegate, Case Western Reserve University; Steven Grable, Delegate, Wright State University; Peter Spatt, Alternate Delegate, Wright State University; Gerrard Baker, Delegate, Ohio State University; Brian Maloney, Delegate, Northeastern Ohio Universities College of Medicine; William J. Todia, Delegate, Medical College of Ohio at Toledo; J.R. Sarpa, President, OSMA-MSS, Medical College of Ohio at Toledo; Richard Nelson, Credentials Committee, Medical College of Ohio at Toledo.

The Ohio delegation was successful at passing a resolution, concerning student loan consolidations. In passing this resolution, the AMA will support legislation in Congress to re-establish a Student Loan Consolidation Association. Such legislation would make it possible for medical students to combine their student loans from various sources into one principal which would be rescheduled for payments over ten years at one interest rate (e.g. 9%). This would be a more convenient and sometimes a less costly way for medical students to handle loan repayment.

The AMA-MSS considered many other resolutions; highlights are outlined below. Action on many of these by the AMA House of Delegates will be forthcoming.

- **Alcohol Advertising:** The AMA-MSS desires legislation requiring that a percentage of alcoholic beverage advertising dollars be spent on advertising the health consequences of excessive alcohol use and on promoting responsibility in the use of alcohol.
- **Dietary Supplement Labeling:** The AMA-MSS desires legislation requiring over-the-counter dietary supplements to be labeled with a warning that excessive dosages may produce toxic effects and, when applicable, what those may be.
- **Food Stamp Program:** The AMA-MSS desires that the USDA restructure the Food Stamp Program to designate that food coupons be available for nutritionally beneficial foodstuffs only.
- **Education on Health Care Economics:** The AMA-MSS seeks development of an educational packet on economic considerations in health care delivery to be made available to medical schools and students for their educational use.
- **Dangers of Ultraviolet Light:** The AMA-MSS desires assemblage and dissemination of information to physicians and the public regarding the dangers of ultraviolet light from sun exposure and commercial tanning centers.
- **Mandatory Assignment:** The AMA-MSS opposes mandatory assignment.
- **Cognitive Services Reimbursement:** The AMA-MSS believes that insurance payers should reimburse physicians equitably for their cognitive services, and not only for their procedural services.
- **Emergency Food Aid:** The AMA-MSS desires that the United States provide adequate amounts of emergency food aid to countries facing imminent starvation.
- **Ethical Review Committees in Hospitals:** The AMA-MSS desires development of Hospital Ethical Review Committees to address ethical concerns in medical care.

The AMA has been criticized as being reactive and closed minded in its approach to today's changes in medicine. But the AMA is only as good as its members. By being active in both the AMA and OSMA, you can ensure that your voice will be heard in organized medicine. **OSMA**

William J. Todia is a medical student at the Medical College of Ohio at Toledo.

SWITCH

An Investigation of Change During Medical School

By Ronald J. Markert, PhD and Alvin E. Rodin, MD

Introduction

In program planning, it would be helpful to the State's medical schools to know how stable a medical student's early preference for a specialty is and why those who switch specialty preference change. This article examines a study conducted at Wright State University School of Medicine (WSUSOM) regarding change of medical specialty choice and the reasons for change. The focus of the article is the primary care physician. The following specific questions were addressed:

1. Overall, how stable is the medical student's early preference for a medical specialty?
2. How stable is the medical student's early preference for a specific specialty?
3. Do the specific specialties increase or decrease in preference during undergraduate medical education?
4. During undergraduate medical education, what changes in preference take place among the specialties?
5. Why do medical students change their specialty preference?

The Wright State Experience

A major goal of Wright State University School of Medicine (WSUSOM) is the graduation of physicians who will practice primary care medicine (family practice, internal medicine, pediatrics). The results for the first four graduating classes have been satisfying. Two-thirds of the graduates in the first four classes (1980-1983) have chosen primary care residencies. However, the medical student's route to his/her eventual choice deserves more careful examination. This study focused on the stability and change of medical specialty choice for the Classes of 1981-1983 and examined the reasons for change among those who switched their choice from medical school entry to the beginning of the residency.

At the beginning of the residency, members of the Classes of 1981-1983 were asked to complete a questionnaire which included (1) their specialty preference at the beginning of their first year of medical school; (2) their anticipated eventual practice specialty; and (3) if applicable, which of 11 reasons influenced a change in specialty from Year 1 to their choice of an eventual specialty. Data for numbers 1 and 2 above were obtained for all 209 graduates in the three classes. Data for number 3 above was obtained from 115 of 121 (95%) of those graduates for whom the item was applicable.

A 42% total stability rate was found, with 88 of 209 not changing their specialty preference from entry into medical school to the beginning of residency. Only four specialties had a sample size sufficiently large to take note of results. Internal medicine with a no-change rate of 65% (13 of 20) was the most stable specialty. Surgery (50%, 12 of 24), family practice (39%, 49 of 126), and pediatrics (33%, 5 of 15) followed. The stability rate for the primary care specialties was 42% (67 of 161).

Table 2 reports increased or decreased specialty preference during medical school in comparison with literature reports. Family practice decreased dramatically in preference during undergraduate medical education from 60% to 30% (126 to 63). Internal medicine increased notably from 10% to 25% (20 to 52). The other specialties either varied not at all or slightly (i.e., pediatrics and surgery) or had insufficient sample sizes (i.e., obstetrics/gynecology, psychiatry, emergency medicine).

Table 3 reports the specific changes of those whose early preference was primary care. For WSUSOM, most notable is the switch to internal medicine. Thirty-two individuals changed from an early preference for family practice to a career choice of internal medicine. Other notable family practice changes were to surgery (12), pediatrics (7), emergency medicine (7), and obstetrics/gynecology (5). Switches from other specialties were too limited

in number to attribute importance.

Table 4 details the reasons for switching specialty choice during undergraduate medical education. The strong influence of the clinical years of undergraduate medical education is evident. The two most frequently cited reasons for change of specialty — a positive clinical experience and an increased awareness of specialties — support the importance of the clinical component of undergraduate medical education in specialty change. In addition, inspection of Table 4 reveals that among the less frequently chosen reasons for change of specialty, clinically related causes are more common than "nonclinical" explanations.

Discussion

The 42% total stability rate for specialty choice between entry and residency for the WSUSOM Classes of 1981-1983 is higher than the 38% median stability rate found at other medical schools (1-11). Comparison of stability rates for individual specialties between WSUSOM and other medical schools is appropriate only for family practice, since that specialty is the only one at WSUSOM with a sufficient number of graduates to permit comparison. The 39% WSUSOM rate for family practice (49 of 126) is higher than the 34% median rate reported in five other studies (5, 7, 8, 9, 11).

For the WSUSOM Classes of 1981-1983, interest in family practice decreased from 60% to 30% (126 to 63). This decline is similar to other studies (2, 3, 5, 7-9, 11-14) in which the cumulative decline in interest was nearly halved from 30% to 16%. Additionally, the increased interest in internal medicine at WSUSOM from 10% to 25% is similar to findings at other schools (1-3, 5, 7-9, 11-14). In these 11 studies, interest in internal medicine increased from 20% to 25%. At WSUSOM a large number (32 of 77) of those switching to internal medicine had chosen family practice as their early preference.

Table 1
Stability of Specialty Choice During Medical School

Specialty	Stability Rate
Primary Care	42% (67 of 161)*
Family Practice	39% (49 of 126)
Internal Medicine	65% (13 of 20)
Pediatrics	33% (5 of 15)
Nonprimary Care	44% (21 of 48)
Obstetrics/Gynecology	33% (1 of 3)
Surgery	50% (12 of 24)
Psychiatry	75% (3 of 4)
Emergency Medicine	13% (1 of 8)
Other	67% (4 of 6)
Undecided	0% (0 of 3)
Total	42% (88 of 209)

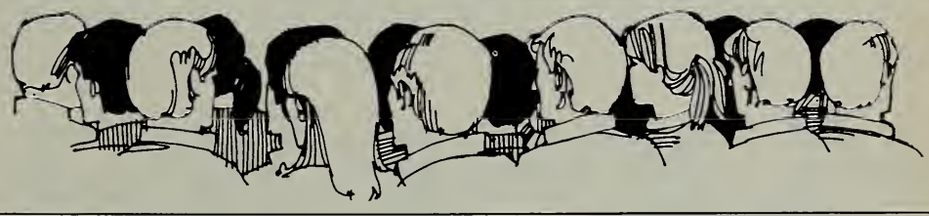


Table 2
Specialty Preference Changes During Medical School

Specialties	Early Preference	Final Choice
Family Practice	60% (126)*	30% (63)*
Internal Medicine	10% (20)	25% (52)
Pediatrics	7% (15)	7% (15)
Surgery	11% (24)	13% (28)a
Obstetrics/Gynecology	1% (3)	4% (8)
Psychiatry	2% (4)	2% (5)
Emergency Medicine	4% (8)	6% (12)
Other	3% (6)	11% (24)b
Undecided	1% (3)	1% (2)

*Number of students ( ).

continued on next page

continued from previous page

Table 3
Specialty Choice Changes From Primary Care Specialties

Eventual Specialty	Primary Care Specialties — Early Preference					
	Family Practice		Internal Medicine		Pediatrics	
	Literature Reports	WSUSOM	Literature Reports	WSUSOM	Literature Reports	WSUSOM
Family Practice	—	— —	27%	14% (1)	20%	10% (1)
Internal Medicine	45%	42% (32)*	—	— —	38%	20% (2)
Pediatrics	12%	9% (7)	17%	14% (1)	—	— —
Surgery	24%	16% (12)	29%	29% (2)	17%	10% (1)
Obstetrics/ Gynecology	12%	6% (5)	8%	14% (1)	8%	0% (0)
Psychiatry	7%	3% (2)	19%	0% (0)	18%	0% (0)
Emergency Medicine	—	9% (7)	—	0% (0)	—	30% (3)
Other	—	14% (11)	—	29% (2)	—	30% (3)
Undecided	—	1% (1)	—	0% (0)	—	0% (0)

**Number of students ( ).*



Table 4
Reasons for Changing Specialty Choice

Wright State University School of Medicine
Classes of 1981, 1982, and 1983

Reason	No. indicating reason	% indicating reason
Positive experience in the Year 3 clerkship or a Year 4 selective in my specialty	83	72
Increased awareness of specialties	81	70
Positive influence of specific WSUSOM faculty in my specialty	49	43
Family or personal considerations	44	38
Negative experience in the Year 3 clerkship or a Year 4 selective in another specialty	42	37
Greater intellectual stimulation	41	36
Physician manpower needs of society	22	19
Negative influence of specific WSUSOM faculty in another specialty	12	10
Location of residency	11	10
Better financial opportunities	11	10
Content and emphasis of the WSUSOM curriculum	6	5

The decrease in preference for family practice (from 60% to 30%) may be related to two factors: admission to WSUSOM and lack of specialty awareness. Among entering students it is common knowledge that WSUSOM has an emphasis on family practice. Some entering students may have been intent on stressing their potential interest in family practice as a means of assuring peer and faculty acceptance during the early stages of their medical education. Additionally, family practice often is the specialty with which entering medical students are most familiar. Thus, there is a tendency to choose family practice as an initial specialty preference. Also, as exposure to other specialties increases, it is not surprising that family practice preference decreases and preference for other specialties increases. Seventy percent (81 of 115) of graduates in the Classes of 1981-1983 who switched specialty preference/choice indicated an increased awareness of specialties as a reason for change. Therefore, the high percentages expressing interest in family practice at entry to medical school may not have represented a fundamental interest in the specialty.

The current study also investigated the reasons for change of specialty from medical school entry to graduation. Overwhelmingly, graduates chose aspects of the clinical years (years 3 and 4) of the WSUSOM program as the most influential causes of change. Thus, as noted above, it appears that the medical school experience tended to decrease the number of graduates who initially were interested in family practice, although this decline did not develop for the other primary care specialties, internal medicine and pediatrics.

Finally, as noted earlier, the primary care physician is at the center of many of the physician manpower issues in the State of Ohio and elsewhere. This paper has demonstrated that one of the State's medical schools is performing better than the nation's medical schools in general in sustaining interest in primary care during medical school as demonstrated by a 42% (versus 36%) primary care stability rate. In addition, with regard to the primary care specialties, WSUSOM parallels

the nation's medical schools in experiencing increased interest in internal medicine, decreased interest in family practice, and unvarying interest in pediatrics during medical school.
OSMA

Ronald J. Markert, PhD, and Alvin E. Rodin, MD are in the Department of Postgraduate Medicine and Continuing Education, Wright State University School of Medicine, Dayton, Ohio.

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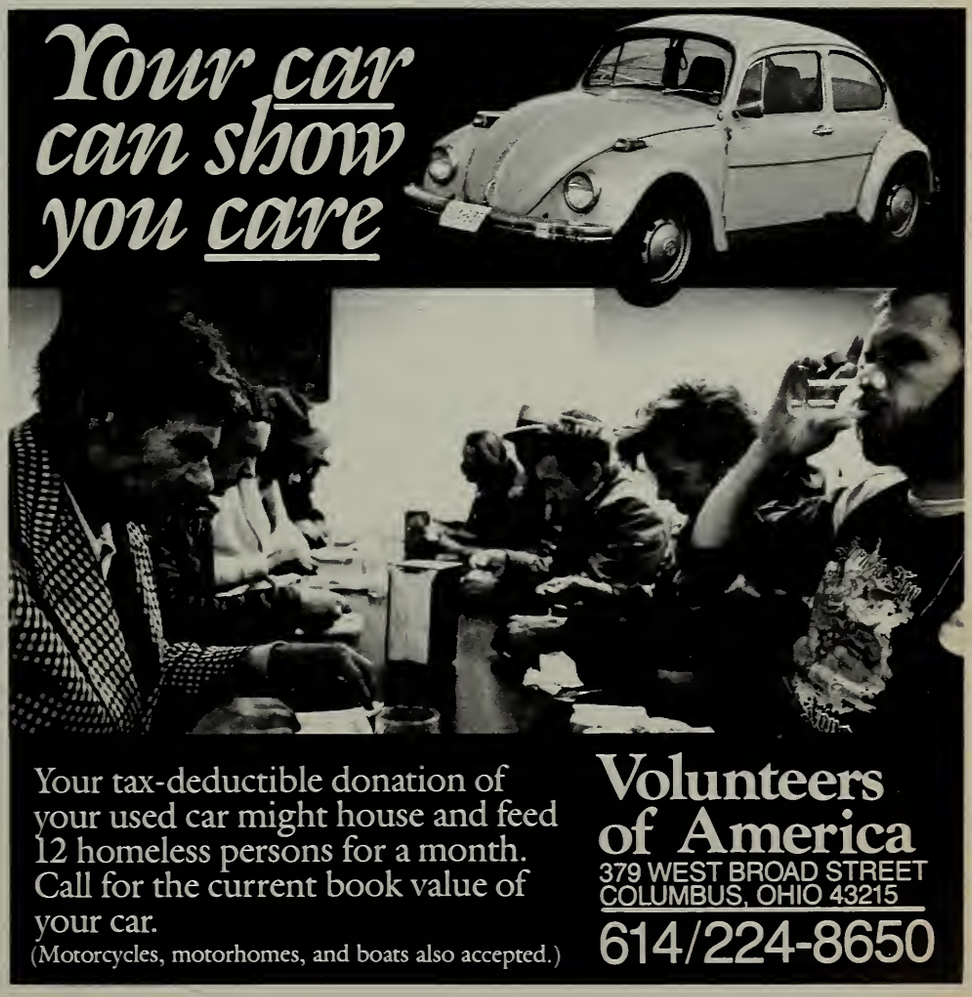
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A look at the literature . . .

Eleven studies published since 1967 have examined medical student stability of specialty choice from early in medical school to graduation or beyond.[1-11] The median stability rate for the 11 studies was 38%. Eight studies have examined stability rates among individual specialties.[1,3-5,7-9,11] Higher median stability rates occurred with surgery (49%), psychiatry (48%), and internal medicine (43%). Lower rates were found for family practice (34%), pediatrics (26%), and obstetrics/gynecology (26%).

Eleven studies[1-3,5,7-9,11-14] have reported increased or decreased preference among the individual specialties during medical school. Internal medicine had a notable cumulative increase (20% to 25%) and family practice a dramatic cumulative decline (30% to 16%). Four other specialties remain about the same: obstetrics/gynecology (4% to 6%), pediatrics (8% to 7%), psychiatry (5% to 7%), and surgery (14% to 16%). With regard to switches from one specialty to another, six studies[1,3,5,7,9,11] found that internal medicine was most frequently switched to (35%) followed by surgery (21%). Family practice switchers most frequently changed to internal medicine (45%) and surgery (24%). Internal medicine switchers were spread fairly evenly among surgery (29%), family practice (27%), psychiatry (19%), and pediatrics (17%). Pediatrics switchers frequently chose internal medicine (38%) with moderate inclinations for family practice (20%), psychiatry (18%), and surgery (17%). Those changing from obstetrics/gynecology tended to choose surgery (37%) and internal medicine (33%). More than half of those changing from psychiatry chose internal medicine (51%). Surgery switchers most often chose internal medicine (49%). — *Ronald J. Markert, PhD, and Alvin E. Rodin, MD*



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Where Are We . . . And Where Do We Go from Here?



An Overview from the Deans of Ohio's six allopathic medical schools

By Karen S. Edwards and Susan Porter

Northeastern Ohio Universities College of Medicine

The youngest of Ohio's six allopathic medical schools, the Northeastern Ohio Universities College of Medicine (NEOUCOM) bills itself as a "unique concept" in its catalogue — and indeed it is.

The school is actually a consortium, consisting of the Basic Medical Sciences campus in Rootstown; three major northeastern Ohio public universities (The University of Akron, Kent State and Youngstown State University); and 17 community hospitals, with a combined capacity of over 6,700 beds.

The school's most unique feature, however, is its six-year combined BS/MD degree program.

"We recruit students directly from high school," says Colin Campbell, MD, Dean of NEOUCOM's Medical School . . . and once they are accepted, the students spend their first two years at any of the three consortium universities studying science, mathematics and the humanities, completing most or all of the required courses for their baccalaureate degrees. The students also attend clinically-oriented symposia during their undergraduate studies to acquaint them with such concerns as types of medical practice, expenses, ethics of practice, medical specialties, etc.

After this, the student begins his or her medical training.

"The freshman medical student concentrates on the basic medical sciences — anatomy, molecular pathology, etc. — for the nine months they are on the Rootstown campus," says Dr. Campbell.

During the sophomore medical year, students study medicine in the ambulatory care centers of the associated teaching hospitals — and the learning continues in their junior

year, as they learn to recognize the physical manifestations of disease and functional disorder, and participate in the management of patient care. The senior medical year is an elective year, designed to help the students make enlightened residency choices. Time, too, is devoted at this stage to medical humanities, in order to reinforce university-based study.

"We feel our program offers two advantages," says Dr. Campbell. "First, we eliminate much of the stresses and competition which accompany premedical studies. Our students are immediately in medical school, once they are accepted, and they know there is not another admission process beyond that. We do give them the MCAT (medical college admissions test) at the end of their undergraduate studies, but we don't expect high test scores. The MCAT just doesn't have much meaning for us."

The second advantage of the six-year combined program, says Dr. Campbell, is the significant cost savings that is realized.

"The combined degree option reduces the cost of attaining the BS and MD degrees by approximately $30,000 when compared to the normal pre-medical and medical route," claims Dr. Campbell. "In terms of the costs, NEOUCOM is a good bargain for the state."

The "bargain", however, has only been in existence a short while.

NEOUCOM enrolled its charter class of 42 students in 1975. By September, 1980, however, that number had increased to 382 students.

"Our yearly freshman medical class enrollment is 105, with the majority of the class promoted from the combined BS/MD programs at the three consortium universities," says Dr. Campbell.

Choosing students to begin the six-year program, however, is tricky, Dr. Campbell attests.

"Unlike other medical schools, we don't have the student's college records to go on — only their high school records."

So, the Admissions committee turns to other things.



Students at Northeastern Ohio Universities College of Medicine spend 9 months here at the Basic Medical Sciences campus in Rootstown, Ohio. Photo courtesy of NEOUCOM.

"We are looking for bright students with high academic achievement — they're probably in the top 5% of their class," Dr. Campbell says. Because MCAT scores are not available, they look to high SAT scores — "at least 1200", and, in addition, they look for evidence that the student cares about people.

"The students we select for our program have usually been leaders in their high schools. They have broad interests and are mature for their age. They relate well to our interviewers," Dr. Campbell says.

"The training we provide has a 'primary medicine thrust', and we do see a significant number of our students going into primary care," Dr. Campbell says.

To bolster that number, however, Dr. Campbell says NEOUCOM will be requiring a one-month primary-care preceptorship of all of its students.

"We'll be phasing it in gradually, but eventually we want all of our students to work with a primary care physician in the area, and experience 'front-line' medicine."

NEOUCOM concerns itself, too,

"We recognize that we need to turn science back to its human side, and so we cover things like medical literature, ethics and morals. We need to teach the student what that means, and what the consequences are."

Once admitted, Dr. Campbell says that the mission of the school is to provide a highly integrated medical educational experience, which will serve the student, whether he or she chooses to practice in a rural community, or in a specialized area of medicine in a highly technical urban medical center.

with teaching its students the human values in medicine, which is, in fact, the name of a course required of all students in their senior year.

"We've been teaching 'Human Values in Medicine' ever since this school started," relates Dr. Campbell. "We recognize that we need to turn science back to its human side, and so

we cover things like medical literature, ethics and morals. After all, in the future, we're going to have to deal with issues like rationing health care. We need to teach the student what that means, and what the consequences are."

Cost containment is also included in this broad-ranging course, "but right now", says Dr. Campbell, "we have no plans for a marketing course — teaching students how to market their practices."

Research, on the other hand, shows more promise.

"We encourage our students to take a summer research fellowship at our school if they can. We don't market it, we just present it as an option. We think it allows the student to see the 'other side' of medicine, as it were. It's certainly more useful than a summer job at McDonald's", he quips.

When it comes to problems, Dr. Campbell says, in many ways, NEOUCOM is no different from the rest of society. "We also wonder about the economy and whether or not it will recover.

"But we have our own concerns, naturally," he says. "For example, like all medical schools, we are concerned with the issue of physician over-supply."

And, more narrowly, he expresses frustration at not being able to own or operate a university health-care facility.

"Still, I have no reason to complain. The hospitals we work with have all been very cooperative, and we have lots of volunteer faculty, without whose help we simply couldn't do what we do."

However, NEOUCOM, he continues, has just about reached the top of its student limit.

"We're at the point where we're going to have to say no more medical students unless we expand existing buildings. More graduate students and residents would be fine, though," Dr. Campbell adds.

All in all, he remains optimistic about the school's future.

"NEOUCOM has bright students and a strong faculty — I have no other reason to believe that the future of our school will be just as bright if not brighter in the years ahead."

Medical College of Ohio at Toledo

Although only in existence a mere 20 years, the Medical College of Ohio at Toledo (MCO) has sprawled from its initial, county-owned facilities at South Detroit and Arlington Avenues in Toledo, into its present, more comfortable, 350-acre site, deeded to the college by the State of Ohio.

The campus now boasts, among its academic buildings, a new 290-bed hospital, as well as a Hospital Support Building, housing a Comprehensive Rehabilitation Center, and a separate Child and Adolescent Psychiatric Hospital.

By the mid-1980s, the expected opening of a major hotel on campus will not only provide a place to stay for continuing education program participants and families visiting patients, but also house those patients from outside the community who are being treated at MCO hospital on an out-patient basis.

The campus has not been the only source of growth, however. An Act of Legislature established the College in 1964 — making it the 100th medical school in the U.S. to receive approval (currently the U.S. has 129 approved medical schools) — and the only free-standing medical school in Ohio (it is not a part of any other college or university). But it was not until 1969 that its charter class was enrolled. At that time, only 32 students comprised the class of '72, but by 1980, class size had reached 150 students, a size that remains consistent today.

According to John P. Kemph, MD, Dean of the Medical School at MCO, the school strives to "prepare medical students with a broad education in the medical sciences (both medical and clinical) for their next step — their residency training."

Although Dr. Kemph admits that the school encourages its students to choose primary care areas, he says that, statistically, the students are split 50-50 between primary care and the other sub-specialties.

"The last decade has been a period of medical schools without walls," notes Dr. Kemph. "The newer medical schools had no university hospitals available in which the student could come into contact with a hospital-



The Medical College of Ohio at Toledo now occupies a 350-acre site, deeded to the college by the State. Photo courtesy of MCO.

based specialist. Instead, they went out into the community for their training — often in the primary care areas, and that was fine, because there has been a growing movement in the community to train students in primary care."

But lately, things have started to change. The newer schools are getting hospitals, or working out arrangements with community hospitals so that the students can have more contact with the sub-specialties — while the older universities, with their established hospitals, are sending their students out into the community for primary care training.

"As far as Dr. Kemph is concerned, MCO is "where we want to be." With a primary care emphasis, the school still has a "sufficiently strong staff of sub-specialists on the faculty," to put them in a better position than other medical schools for their future.

While MCO's curriculum is best described as a traditional, four-year program ("We gave up the 3-year program because there was not enough faculty," claims Dr. Kemph), the training is "dedicated to education and patient care" — and both Dr. Kemph, and MCO's catalogue quickly point out the school's enthusiasm for medical and scientific research.

"We offer our students the opportunity to work in a summer research program between their first and second year," Dr. Kemph says.

A stipend of $1,200 is provided the student (along with equipment and supplies) for the 3-month period. They write proposals, much as they would if they were actually in the research end of medicine, and a faculty advisor works with them.

"We've seen this program grow from 25 students to 55 or 60 at present," Dr. Kemph adds.

One of the reasons for this growth is that MCO actively markets this research program. "We feel that the program helps lure the student into academic and research work and makes a better clinician of him or her," notes Dr. Kemph.

He points specifically to the research program currently being conducted in the area of hypertension. One study, funded by the National Institute for Health, is examining the relationship of the endocrine system to hypertension, and Dr. Kemph suggests that findings may be very significant.

MCO has been on top of things, too, in the area of "current affairs".

"We were the first school in the nation to introduce the significance of costs into our teachings," says Dr. Kemph — and that was 10 years ago. It became a part of the introduction to clinical medicine courses, and became incorporated into the general medicine and preventive medicine programs.

"We also introduce ethics to our students in their first and second year, and teach both theoretical and practical nutrition."

So the education the MCO student receives is well-rounded.

Whether it will become even more complete is a question yet to be answered.

"We were the first school in the nation to introduce the significance of costs into our teachings."

A long-range planning committee met this past August to review the school's curricula — looking for indications that changes needed to be made.

"Certainly pressures for change are coming in the area of clinical service," says Dr. Kemph. As he points out, the rapid rise of health-care costs are creating new priorities — making it necessary for medical schools to focus more and more of their attention on clinical training, since "increasing patient loads in university hospitals result in increased income."

That increased income becomes substantially important in view of diminishing resources from other sources.

"We are coming to the point where we will have to put more emphasis on the clinical side of medicine, and less on the research, and that is tragic.

"Tragic because the only way anything is learned in medicine is by sitting on a lab bench and conducting studies into areas that have not been explored before. This new emphasis, however, is going to force us to change our goals and focus over time."

University hospitals, as Dr. Kemph notes, will always be expensive and subject to cost scrutiny.

"The student has to order tests that the experienced specialist may not have to — simply because the student is still learning and not quite sure." And once the DRG system is in place for hospitals,"we're bound to have some serious problems with our funding," Dr. Kemph says.

He is not overly concerned with the area of physician oversupply — at least in the Toledo area — and his statistics back him up. Of the 101 seniors who graduated in 1983, 52 remained in Ohio (24 actually in the Toledo area) while 49 went outside the state for their residency programs.

"We won't really know whether or not there will be a physician oversupply until the time comes," says Dr. Kemph.

"Of course, if we weren't under economic restraints, we wouldn't even be talking about oversupply," he adds. "We should let the issue float with the marketplace."

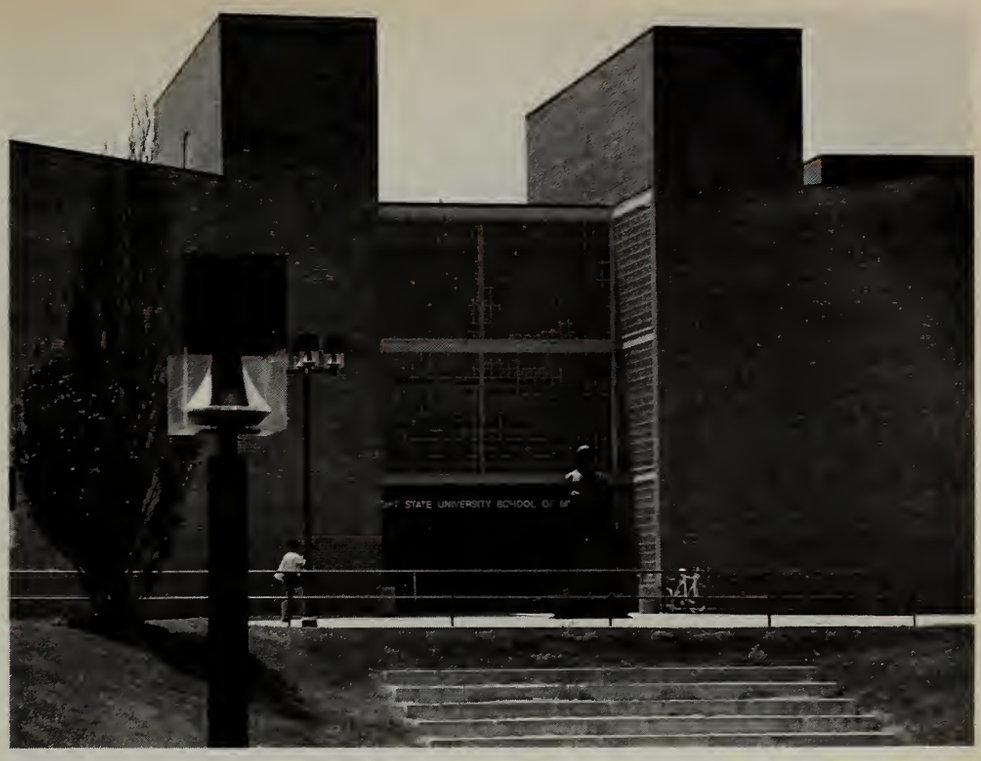
Have MCO students changed much over the years?

"Their qualifications seem to remain consistently high — with grade point averages of 3.4 to 3.5. But the type of person going into medicine seems to be changing," Dr. Kemph notes.

They're more serious, less rebellious than the students of the '60s and early '70s, he says, but they're not willing to perform in quite the same way. They're not willing to stand nights by the phone. They want set hours — and time for themselves.

Perhaps that's just a reflection of the times — of the "me" generation, as the '80s have been called. Yet, as medicine becomes more and more complex, and physicians are called on to make ethical, moral and technological decisions that never even had to be considered before — the idea of more time for oneself, in the context of things, becomes perfectly understandable.

Wright State University School of Medicine



At the Wright State University's School of Medicine, students follow a community-based medical curriculum. Photo courtesy of Wright State.

What began in 1964 as a "branch campus," operated by both Ohio State and Miami Universities, has evolved over time into an independent, state-assisted university with its own identity — and its own medical school.

It was in 1973 that Wright State University, in Dayton, established its School of Medicine "to help meet society's need for high-quality primary health care," as its catalogue puts it. In fact, Wright State medical students have, for the most part, chosen careers in the primary care area. Of the first class of 31 students, 70% of them chose a career in pediatrics, internal medicine, obstetrics/gynecology, and family practice.

"I'd say that our school is still dedicated to stressing the need for more primary care physicians," says J. Robert Suriano, PhD, Dean of Student Affairs and Admissions at Wright State.

This is done primarily through a community-based medical curriculum, he explains, which means that, in addition to traditional classroom activities, students receive on-line experience in hospitals, clinics and physicians' offices located throughout southwestern Ohio.

"Our program is structured to stimulate our students to select the primary practice care area," Suriano says.

In addition to achieving a high success rate in "meeting society's need for high-quality primary health care," Wright State is also proud of the number of unrepresented minorities the school is able to attract.

"Approximately 10% of our students are unrepresented minorities," Suriano says, but that figure has only come about in recent years.

"Twelve or 13 years ago, there were maybe 50 blacks among 1,500-1,600 applicants. Today, for every 1,300 applicants, there are probably 100 blacks."

Suriano says the reason for the increase may be due, in part, to Wright State's active recuitment program.

"With our 'Horizons in Medicine' program, for example, we select students from the greater Dayton area, and for eight weeks, we expose them to a medical school environment. They learn about the medical sciences, work in the labs, meet our faculty. And we're finding that those students who have gone through the program are selecting to go on to medical school as their college careers come to an end."

At the college level, recruitment takes the form of programs which encourage work opportunities with faculty members in the basic sciences.

"Right now, we are beginning to see fewer numbers of blacks and hispanics applying for school — but the number of women applying is raising rapidly. I'd say they now represent one-third of our total number of applicants."

According to Suriano, the qualities they are looking for in an applicant are "a strong, intellectual ability, a good academic background, and personal qualities — their interest in and dedication to people. We want to know if they can interact well with others. Are they mature? And are they capable of continuing their learning process after they graduate? That's important."

The group of applicants they attract is a heterogenous group — not only with regard to minority; it is also diverse in age, experience, background, lifestyle and attitude.

"Each application is individually reviewed," says Suriano, and, he adds that Ohio residents receive strong preference over out-of-state students.

Once the applicant is admitted, they receive, the first two years, a solid foundation in the basic biomedical sciences — "but we also expose them to the clinical side of medicine, usually in ambulatory care settings," Suriano explains. The third year consists of full-time clinical experiences, and the fourth year allows the student to pursue individualized, professional activities.

"The subject of cost is not taught to our students in a formal sense, but they pick it up, informally, through their exposure to practicing physicians," Suriano says.

The nebulous subjects of religion, ethics, sociology, and law are wrapped up into a required course the students receive in their freshman year.

"We also offer some interesting electives. For example, a course on legal medicine is offered in conjuction with a group of law students. A course on medicine and religion is offered in conjunction with a group of theology students. Each side gets two perspectives of the problems discussed.

"Our curricula has, over the past 10 or 11 years, continued to evolve — to

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keep pace with the way medicine is evolving. We are always looking for ways to change, to keep the students abreast of what is going on in the world of medicine," he says.

And that's one of the biggest problems Suriano says all medical schools are currently facing.

"There is so much more information we have to teach today," he explains. "The socio economic side is just a part of it. Technological advancements and research have opened up new areas that didn't exist before — and that means there is more knowledge that we have to impart to our students. It's difficult to get a handle on all of it — and it is getting more and more difficult to teach the student everything he or she needs to know in four year's time."

The problem is not one that will go away — and, in fact, it will probably get worse as medicine continues to advance.

So, too, will the problem of cost.

"The cost of health care is currently so high that we're going to need to put restraints on somewhere. But how are we going to teach this?" Suriano asks.

It is not the rising cost of health care that is concerning most medical students, however, Suriano notes — it is the cost of the medical education itself, and that is rapidly becoming the number one problem for medical schools and medical students alike.

"Despite the fact that the cost of a medical education keeps increasing — and the level of indebtedness continues to rise — the availability of resources has continued to decline," Suriano says. "That's going to create problems in the years ahead. It's going to get to the point where no one will be able to afford a medical education."

Already, costs are affecting a student's specialty choice, Suriano says.

"When you've acquire a heavy debt, you're going to choose a specialty that will better help you relieve your financial burden," Suriano says, "whether that would be your first choice or not."

Like the other newer and somewhat smaller medical schools, Wright State does not have its own hospital, but has entered into affiliation agreement with a number of community hospitals.

"We really don't have any need for our own facility," Suriano says. "Besides the community hospitals, we're also able to use the VA and Wright-Patterson hospitals.

"The community hospitals are very important to us," Suriano continues, "They have been very cooperative, and we have an excellent relationship with them. We think they offer our students a role model in those areas which we are stressing at the University."

And for a University that is attempting to meet the community's need for "high quality primary care", the community role model seems to be just what the doctor ordered.

University of Cincinnati College of Medicine

Since 1805 when Daniel Drake became the first person in Ohio (and west of the Allegheny Mountains) to earn the title MD, Cincinnati has been a hub for medical education in the Midwest. Currently the 12th largest medical school in the United States, the school dates back to 1819 when Dr. Drake returned to the area to open his "Medical College of Ohio" in a single room over a Cincinnati drugstore. Its first 24 students graduated in 1821, and in 1896, it was joined with the University of Cincinnati to become its College of Medicine.

As in the early days, the college continues to hold a reputation for innovation and excellence, and its requirements for admission have remained stringent. Nearly 5,000 applications are received each year for the 192 positions in the entering class. Because it is a state-supported college, 80% of those accepted are from Ohio.

Students must have a minimum of 90 undergraduate semester hours prior to admission; most hold bachelor's degrees. Applicants also are required to take the new MCAT. Selection is based not only on the basis of test scores but also on the students' overall academic records, involvement in research activities and independent projects, clinical activities, letters of evaluation and interview results.

While a strong basic sciences curriculum continues to underlie the medical school program at U.C., a number of recent changes have resulted in a more clinically-oriented approach. These changes were implemented after an extensive curriculum review process was initiated by the dean of the medical school in 1978.

"Prior to the changes, students followed a more traditional, two-plus-two format: two years of basic sciences, followed by two years of clinical sciences," explains Robert S. Daniels, MD, dean of the medical school. "Today the curriculum is organized so students are introduced to clinical experiences in a continuum" — starting with some short clinical projects the first year and ending with an extensive clinical program by the fourth year.

Thus, freshmen students meet with hospitalized patients their first quarter in school and by the second quarter are learning to take patient histories. By spring, first-year students spend an afternoon a week with a practicing physician, either in a private office or clinic. During the second year, students visit teaching hospitals weekly, learn to do physical exams and discover the basics of diagnosis.

Sophomore students also may now elect a new "Family Care" course which allows them to follow a pregnant woman and her family through pregnancy, delivery and postnatal care.

Closely linked with these changes was the opening of an Area Health Education Center in Cincinnati, a government-sponsored program which simultaneously provides clinical educational opportunities for students and outpatient health care for residents of underserved areas. According to Dr. Daniels, the center covers rural areas within a 50 to 60 mile radius of Cincinnati. "Students now spend about 10% of their clinical experiences at rural sites," he says.

The center fits well with the university's goal to prepare students for medicine in the future. "In the past inpatient care experiences dominated the clinical biennium," says the most

recent issue of the U.C. College of Medicine Bulletin. "With social trends to reduce hospital stays, limit costs and provide health care to underserved areas, considerable training in outpatient care was considered essential for students."

Other changes resulting from the curriculum review process include more emphasis on the behavioral sciences, including topics such as human sexuality, death and dying, ethics, drug and alcohol abuse and the ethical and legal aspects of genetics. "We have also been much more active in teaching geriatrics over the last four to five years," says Dr. Daniels, along with courses in nutrition, exercise and the "wellness" concept.

Many of these topics are offered as electives or have been incorporated into other coursework, and thus represent subtle changes in the curriculum, Dr. Daniels notes. More important are changes in the process used to plan, monitor and regulate the curriculum, which have made it easier to continue to restructure the medical school program as medicine, itself, continues to change.

"We are now working to improve our offerings in ethics and values, death and dying and the economics of medicine," Dr. Daniels says, adding his belief that the cost of medical care delivery will continue to be a dominant issue in years to come.

Among other unique courses now offered at U.C. is an interdisciplinary "Human Awareness" course which allows freshmen and sophomores to interact with students in nursing, social work, clinical pharmacy and other allied health areas. Students also are prepared for the "legal and ethical issues in medicine" in a course of that title.

Today's medical schools are "where most of the nation's biomedical research gets done, and a substantial portion of health care is delivered."

Approximately half of U.C.'s medical school graduates now choose residencies in primary care areas: internal medicine, family medicine, general practice or pediatrics," Dr. Daniels says. "The rest are a fairly complicated mix," representing a variety of specialties and subspecialties, while, "a fair number go into research or academic careers," he says.

With the largest research holdings of any college in the state — some $24 million in grants is currently allocated to the research program there — Dr. Daniels points out that U.C.'s College of Medicine is more than simply a place where students are educated. "Student education is actually a small part of what we do here, although it is the primary reason we are here," he says. "We also supervise 600 staff residents and interns and 250 graduate students."

Along with the nation's other 128 medical schools, U.C. is one of the places "where most of the nation's biomedical research gets done, and a substantial portion of health care is delivered here," Dr. Daniels continues. "We see some 400,000 outpatient and emergency cases each year — we are the largest deliverer of medical care in southwestern Ohio and the neighboring areas of Kentucky and Indiana."

Still, a goodly portion of the school's $800 million budget and 700-full time faculty are dedicated to the important business of educating tomorrow's doctors, whom Dr. Daniels describes as "a very diverse group." He adds, however, "We try for diversity. We pride ourselves in the fact we seek out students with a broad range of interests."



The University of Cincinnati's College of Medicine has recently changed its curriculum to a more clinically-oriented approach. Photo courtesy of the University of Cincinnati.

Ohio State University College of Medicine

In 1913, the Ohio Legislature authorized the establishment of the Ohio State University's College of Medicine, although the roots of the school date back to 1834 when the Medical Department of Willoughby University on Lake Erie was first chartered.

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Today the college of medicine consists of 18 departments and two schools. Its physical facilities make up an extensive complex on the OSU campus in Columbus and include an administrative center, numerous classroom/laboratory buildings, and a health sciences center made up of the various University Hospitals and clinics and totaling some 1,000 inpatient beds.

In 1980, the faculty of the OSU College of Medicine voted in a new curriculum calendar, changing the school's three-year MD program to a four-year program. It retained, however, OSU's innovative Independent Study Program (ISP) which allows students to complete their freshman and sophomore years of schooling in whatever time frame they require.

According to Manual Tzagournis, MD, dean of the medical school at OSU, the ISP is known throughout the country and was one of the first to make considerable use of the computer for self-study and self-evaluation purposes. "Students go at their own pace and study what they choose," he explains. "For instance, one student may spend very little time in a physiological chemistry, but need a lot of work in anatomy. Also, they can work any time, day or night."

The purpose of the program, Dr. Tzagournis says, is to meet the individual needs of those students who learn better independently; roughly one-third of the class is in the program which has become so popular that some applicants have to be turned away. "Some students learn better by lectures and notes," he comments. "Others by digging out the information on their own. There are different kinds of learners. We are trying to accommodate all of them."

Studies and test scores indicate that students do equally well in both programs, says J. Hutchison Williams, MD, dean for student affairs at OSU and former Councilor of the OSMA. "Like any good program, the ISP has a lot of hidden structure," he says, adding students work on a one-to-one basis with faculty and take tests at the end of each module of learning they complete. Whether they choose the traditional 4-year program or the ISP, students must come out with the same knowledge and skills, because "The National Board of Evaluation criteria are the same for all students," says Dr. Williams.

According to Dr. Tzagournis, the goals of both programs are the same, as well — "to provide a very firm foundation and background of information for the training of the physician, so he or she can enter into any specialty he or she might choose."

OSU also makes some effort to teach students about the changing climate of medicine and offers seniors a one-day seminar on practice management, which covers money management, taxes, banking, equipment leases, etc. Also, a one-quarter elective in health policies, covers alternative health care systems such as HMOs and PPOs, rules and regulations governing Medicare and Medicaid, and other structural and financial aspects of medicine.

However, "The real mission of our educational institution is to prepare students didactically," Dr. Williams says. "There is a certain amount of didactic material that has to be taught. We do attempt to teach students some things about these other phenomena, but we find it doesn't really hit home until they go out into practice. For most of our students, that's at least four years away, and the climate of medicine is in such a state of flux that what you teach today may not be applicable tomorrow."

OSU students also participate in preceptorships, spending time each week with a faculty member in practice along with two or three other students. Through these small group sessions, students are expected to gain perspectives on physician ethics and lifestyle, as well as the clinical and management aspects of a medical practice.

Students also are encouraged to partake in research projects while they're in school; through the Roessler Foundation, a private philanthrophic foundation, which provides grants for such projects, medical students may participate in either full or part-time research. Some 50% take advantage of these and other research scholarships, Dr. Tzagournis says.

Like all medical schools in the state, "OSU is facing the question of whether or not we're producing more doctors than we need — this is



At the Ohio State University's College of Medicine, a new curriculum calendar changed the school's three-year MD program to a four-year one. Photo courtesy of OSU.

something we've been talking about a lot over the last two years," Dr. Tzagournis says. "It is possible that some plan will have to be devised to decrease the number of medical students, due chiefly to the expense of a medical education. It is very expensive and the (tax) burden on the state is high." Prior to the recent tax increase, Ohio's medical schools — along with all of higher education — were facing severe financial problems, he adds.

But Dr. Tzagournis is in hopes that more of the burden will not be shifted onto students, many of whom already are having difficulty making ends meet. "As a public institution, it is our duty to provide all students in Ohio with an affordable education," he says. "Therefore, we try to keep our tuition and costs down. And I think we've been successful at that, when you compare our $4,000 annual tuition to the $20,000 some private institutions are charging."

Because it is a state-supported school, the majority of OSU students are Ohio residents, but they represent a diverse group. "We range from the very rural areas to rather sophisticated metropolitan cities," Dr. Tzagournis points out. "Therefore, we see a good cross section of students here."

And while medicine is changing dramatically, the students are not, in his opinion. "I still see a very committed group of young people with very high grades and standards," he says. "Changes in their goals and attitudes are not so much those of the individual as those of society. Twenty years ago or so, the trend was to go into private practice. Now it's group practice. This is a result of an influence greater than any fixed plan the students might have."

He also notes a growing trend towards choosing the primary care specialties, due chiefly to public attitudes and perceptions of need. "There's an emphasis today that this is what is needed, more than the subspecialists," he says. "The subspecialists had their day in the 1960s and 1970s. Today there are greater opportunities in primary care — so that's where the students are going."

Case Western Reserve University School of Medicine

The School of Medicine at Case Western Reserve University dates back to 1843, when it was organized as the Medical Department of the Western Reserve College, in nearby Hudson, Ohio; but from the beginning, the medical school was located in Cleveland.

At first, classes were held in downtown Cleveland, but in 1915, a 20-acre site in University Circle was set aside for the medical school, as well as various university hospitals and clinics.

The school has continued to expand in various capacities since that time. But, in more recent years Case Western has concentrated on expanding the school's *curriculum*, currently organized around an interdisciplinary, organic systems approach to biomedical education, as opposed to the more traditional departmental structure.

The faculty also recently approved a three-stage report on curriculum revitalization which consists of three components: a core academic program, which provides the fundamentals; a flexible program, which provides the student with independent study options; and a patient-based program which provides the clinical experience.

According to Robert Griggs, MD, dean of student affairs at Case Western, this more integrated approach is designed to give students a basic foundation for future work as physicians in a variety of specialty areas.

Because scientific and technological advancements have been so great and time is limited, special subject committees representing faculty from each department work together to decide which areas should be covered, who should teach them, and how best to foster within students good habits for self-education, skills for problem solving, and a continued enthusiasm for the medical sciences.

"Obviously there has been an increase in the technological knowledge we have to teach students," Dr. Griggs says. "But we also are trying to integrate into our curriculum, in various ways, the image of the physician as a human being interested in other human beings."

For example, "To help beginning students develop appropriate attitudes towards their responsibilities as physicians and members of their communities, each first-year student is assigned to a family in which the mother is pregnant," according to the school's most recent Admissions Handbook. " The student serves as a personal connecting link between the family and the health services available through the University Medical Center. The student participates in the care of the mother and later of the infant."

In addition, "This program provides a basis for significant relationships with physician instructors in the clinical science program and in the obstetric, pediatric and family practice clinics," the handbook continues.

Other new and unique course offerings at Case Western, according to Dr. Griggs, include special offerings in information management, biomedical ethics, aging, occupational medicine, health care management and geographic medicine (medicine in third-world countries). This fall, a special new geriatrics program will be offered and by next fall a new environmental sciences program will be in place.

The latter program will include coursework in genetic toxicology, occupational medicine and environmental hazards in the living and working environment. "Physicians need to know more about these hazards in the environment," Dr. Griggs explains. "We are trying to pick out those areas where physicians will need added knowledge and skills over the next two decades."

In addition, courses in aging and geriatrics, health management, health care financing and geographic medicine "are evolving because we have faculty members who are very interested in these areas." Because the medical school recently took over the

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university's department of nutrition, course offerings in that area also will be more accessible to medical students.

Still, students face a variety of problems that Ohio's medical schools are not yet prepared to deal with. "Financial problems are obviously one of the largest," Dr. Griggs says. "We are trying our best to keep down rising costs, so students don't go out of here with too much debt." The average debt of a Case Western graduate is approaching $30,000, however, and there's "a wide range of indebtedness, from zero to $80,000," says Dr. Griggs.

Among the major challenges facing the medical schools themselves are "trying to attract minority students," as well as "trying to emphasize student individual values and those of their patients," which can be difficult "in the face of high-tech medicine, particularly with so much education taking place in tertiary care units," says Dr. Griggs.

One way the latter goal is being met is through the Area Health Education Center affiliated with Case Western. "Ours is unique, in that it is an urban center," Dr. Griggs says. "Inner city Cleveland is our territory. Through that effort, most of our students get some experience working with individuals who are medically indigent — not the typical patients in our hospitals. They also are exposed to those physicians dedicated to working with these people."

Like the patients they see, medical students at Case Western represent a diverse group, according to Dr. Griggs. "Our student body is a little different than most," he says. "Only half are what we call 'straight arrows' — right out of college. The other half have already worked in a wide range of areas — some are up to 43 years old — and many are women."

While women currently make up 38% of the medical school class at Case Western, they compose 46% of the freshman class, reflecting a nationwide trend towards more females in medical schools. Case Western also boasts a high percentage of medical school graduates who remain in Ohio for their residencies — some 40% to 45%.

While Dr. Griggs sees "no striking or unique things about the (specialty) areas they choose," he does note that more are picking specialties in "the better paying" areas, including ophthalmology and radiology. Case Western has fewer medical students than the national average choosing careers in family medicine, although "a fair number" do go into research and academics, according to Dr. Griggs.

"I think many of them are worried about all of these things we keep reading about in the paper — the restructuring of the economics of health care. They wonder about it and what's going to happen to them."

And while Case Western is making some attempts to prepare its students for that future, a good number of the problems these students will face remain unknown and thus unanswerable, he says. **OSMA**



Case Western Reserve University has a diverse group of students — some straight from college, some who have already worked in a wide range of areas. Photo courtesy of CWRU.

Karen S. Edwards is Executive Editor of the **Ohio State Medical Journal.**

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Where Are We . . . And Where Do We Go from Here?



Viewpoints from Six Ohio Students

By Karen S. Edwards and Susan Porter

Joseph L. Lydon, Jr.,

Case Western Reserve University School of Medicine

"If I was sure of anything, it was that I didn't want to go into medicine," says Joseph L. Lydon, age 23 and now a junior at the Case Western Reserve University School of Medicine. But after obtaining a bachelor of science degree from Boston College, the Rocky River, Ohio native reconsidered.

"I wanted a career that would be interesting and that would necessitate learning all of the time," he says. "I wasn't interested in some 9 to 5 job that required little creativity or thinking. And I knew a career in medicine would be a challenge."

The Case Western program, which offers students the chance to interact with patients beginning "the first day you walk in," has helped Lydon focus more clearly on his goal. "We are given a family to follow through the first two years," Lydon explains. "First we help care for the pregnant mother, and then for the child. It gives us the opportunity to hone up on patient interaction skills and it helps us develop a sensitivity to the emotional needs of patients."

Lydon also appreciates Case Western's "anonymous grading system" which uses test scores simply to let students see their own progress and shortcomings. "It's strictly a pass/fail system," Lydon explains. "There is no numerical ranking of students based on their grades. Students put enough pressure on themselves without that kind of ranking. And the faculty constantly reassures us that the important thing is how we use our knowledge — how we pull it together for the benefit of the patient."

"I wasn't interested in some 9 to 5 job that required little creativity or thinking. I knew a career in medicine would be a challenge."

While he has not yet decided on a specialty, Lydon feels that nearly all areas of medicine will require his continued professional and personal growth and development. He is hoping the clinical rotations he is now beginning in his junior year, will help him focus more clearly on that particular area which will give him the most personal satisfaction.

"I change my mind almost every day," he says. "My only concern is that I choose a field that is interesting and necessitates constant learning and adaptation. This will be the reason I choose a specialty. How much work is involved — the number of nights I might be on call — is not nearly as important as how happy I am — how interested I will be in what I'm doing."

He also hopes to gain from a career in medicine "the personal satisfaction of knowing I was able to make a difference in someone's life — that I am providing a necessary service." And although he is incurring a substantial amount of debt in his training ("I try not to think about it," he comments), he is not in medicine

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for the financial rewards it may bring. Nor will that have any impact on his choice of specialty.

"One is very foolish to try and choose a specialty in terms of its income bracket," he adds. "The money aspect of medicine is just too unpredictable."

Also unpredictable is the climate of medicine Lydon and his fellow medical school students will be practicing in over the next several decades. Through a number of elective offerings at Case Western which touch on aspects of medical economics, practice management, hospital structure and finance, students may gain some perspectives on the future, says Lydon.

"But I think we first need to learn the science and the art of medicine, before we take on all of these other aspects," he says. "These are important areas, but I don't think they belong in the core program next to anatomy and physiology. They can always be included in seminars later."

The core curriculum does, however, include certain course offerings containing information and guidance on physician lifestyle and ethics, including a clinical science course which covers "patient care, patient management and emotional issues concerning the patient and the physician," according to Lydon. "There is also a substantial amount of teaching on the impaired physician in short courses we call 'committees'," Lydon continues. "One very excellent one is a four-week program on clinical psychiatry, which spends some time dealing with the personal aspects of being a physician."

Lydon notes there also is a growing emphasis in his coursework on cost-effective medicine. It is not uncommon for a professor to say that a certain test or antibiotic has proven effective in the diagnosis or treatment of a particular disease — but that it is very expensive and therefore should be used sparingly, he says.

"Consciousness of health care costs are also very prominent in our hospitals," he continues. "With the implementation of Diagnosis Related Groups, there is a real effort not to be foolish or foolhardy — it's very easy to forget we don't really need this test."

These efforts, Lydon believes, represent a marked change in emphasis, both in medical schools and in the practice of medicine, itself. "Ten years ago, physicians wouldn't have worried about cost. Now they have to."

Lydon views this new emphasis on cost-effectiveness optimistically. "I do think there's a substantial amount of fat that could be trimmed out of the (health care) system," he says. "I believe this will result in a more efficient, more effective, improved system of health care delivery.

"My only concern is that it not affect the quality of care," he continues. "But I think we can provide the same quality of health care more efficiently and effectively and at a lower price."

Lydon also is unconcerned about increasing competition in the medical profession and the potential for an oversupply of doctors in the future. "There will always be a need for good doctors" he says. "And I don't think we can predict exactly what the future will bring. When the present baby-boom generation reaches old age and begins to need a lot more health care, the so-called 'physician glut' everyone is talking about may turn into another physician shortage."

What he is concerned about, however, is the financial ability of future medical students to attend school — not just in Ohio, but nationwide. "Tuitions in medical schools are not uncommonly in excess of $15,000 a year," he says, "and there are some schools in the East up to $26,000. It's possible that we could eliminate everyone but the very upper class — that we could end up with an aristocracy in medicine.

"Not only would that reflect badly on the medical profession," he continues, "but it's important that we have the entire cross section of society in medicine — that we continue to attract people who understand and who care about all kinds of people."

Linda Elaine Weber,
Ohio State University College of Medicine

"I had always wanted to be a nurse," says Linda Elaine Weber, 26, who is entering her senior year at Ohio State University's College of Medicine.

"But I had grown up in a small town, Novelty, Ohio, at a time when girls became nurses and boys became doctors — and there wasn't much crossing of boundaries."

In fact, it wasn't until she reached Case Western where she received both her bachelor's and master's degree in psychology, that the stereotypical image began to crumble.

"I knew I wanted to be a nurse-midwife, and I like being educated — knowing that I'm as capable as anybody else in the room to get the job done — so I know I would have picked up the two-year masters' program in nursing," she says.

But after thinking about it, she realized that would have meant seven



years worth of nurse's training, and in eight she could become a doctor.

"After some further encouragement from friends, that's the position I decided to pursue."

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Although she began her application process rather late (most of the classes had been filled by the time I was interviewing") she says she didn't run into any difficulty being accepted.

"My grade point was at least 3.5, and I had done all the suggested activities — I had done research, worked in a hospital, things like that."

For the most part, her interviews went smoothly.

"But there was one incident — at Wright State — when an interviewer asked me about my dating habits. I mentioned I was engaged and, immediately, I was asked what my fiance thought of my being in medical school. I answered the question, but I felt it was inappropriate, that they probably wouldn't have asked it of a male applicant. What really surprised me, though, was that the interviewer was a woman."

Weber has since endured other gender indignities, but she sloughs them off.

"I'm often called 'nurse'," she says, "but it doesn't bother me anymore. I don't care if they call me by my first name if it makes the patient more comfortable," she says.

She recalls, however, an incident that happened recently when a male colleague told her a patient had just referred to him as "nurse." "Now I know how you feel," he said.

The answer she gave the female interviewer, that day, however, must have been satisfactory, as she was accepted by Wright State — and by Case Western, and OSU. She finally chose OSU "because overall it had just as good a reputation (if not better) than Case, and the tuition wasn't as high."

Still, education, especially a medical education doesn't come cheap.

"I'm about $30,000 in debt right now. Fortunately, I only have a $1,200 debt left from my undergraduate education, so I don't feel I'm doing that badly."

Weber has financed her education through loans and some scholarships.

"It's not much, about $150 a quarter, but I never turn down money," she laughs.

She's done well, so far, at OSU's School of Medicine. She was president of her freshman class; has served as president, vice-president and treasurer of the medical school's student council; has actively participated in both the OSMA's Medical Student Section (since its inception), and in the family practice interest group at OSU. She's been made a member of the honorary Alpha Omega Alpha, and has been presented with the Russoff Award, which honors those with the highest academic achievement.

She's concerned with too much fragmentation in health care, and feels that a physician really needs to know the patient. That's why she's interested in family practice.

So what lies ahead for Linda Weber?

"I'd like to open a family practice in a small town," she says.

She's concerned with "too much fragmentation in health care" and feels that a physician really needs to know the patient he or she is treating. "You need the whole picture — to know the environment they're living in, the types of stresses they're handling. I'd say at least one-quarter of any practice is based in psychology — talking and listening to the patient."

Country living appeals to her — "and a family practice is more feasible in that kind of environment" — but that's not the reason she's chosen to pursue it.

"It's more satisfying than some of the other specialties. I like the personal touch that family practice affords."

She realizes that there is not as much money to be made in that specialty — especially in rural areas.

"But I don't feel that my debt is so handicapping that I can't get out from underneath it."

Besides, she adds, she doesn't need a flashy lifestyle.

"My father was a blue-collar worker, so I didn't grow up accustomed to, or expecting wealth. I can get by on a much lower lifestyle if necessary."

She figures, though, that she can take advantage of the moonlighting opportunities open to residents . . . "and my fiancee (who is presently a family practice resident at Grant Hospital in Columbus) can help out."

The two have tentatively set plans to return to his hometown to practice, but Weber admits that if she weren't considering a small-town practice, an HMO would be a tempting alternative. There is something about guaranteed hours, and a guaranteed salary in what is proving to be a more and more unsettling profession.

"There are problems that need to be examined in the medical area today," she says.

For example, the case of Baby Doe is far from settled, she claims, and malpractice has "simply reached the point of being ludicrous."

"I'm insulated from it as a student, and perhaps I won't have as many problems with it as a family practitioner — where you know your patient, and they know you. But I can't help but feel it's going to affect the way I practice medicine. When I order a test, or don't order a test, there will always be a question at the back of my mind, 'Will I be held responsible for this action later?' Perhaps there should be penalties instituted against those who falsely sue someone — but something needs to be done. Malpractice is skyrocketing health care costs."

Still, she is looking forward to her career in medicine — and an eventual small-town practice. Like all good things, it will come with time, and a modicum of patience.

Eventually however, Linda Weber will prove to Novelty, Ohio (and wherever else doubts may exist) that boundaries can be crossed. That little girls can, and do grow up to be doctors.



John P. Crow,
Northeastern Ohio Universities College of Medicine

"I like the challenge that surgery offers — of being able to work with my hands," says John P. Crow, 23, who will graduate next May from the Northeastern Ohio Universities College of Medicine (NEOUCOM).

Crow comes from a small town, Danville, midway between Akron and Columbus. "We used to drive to Columbus to see a movie," he recalls. His father is a plumber, and that's where he claims he picked up his interest in working with his hands. "When I was little, I used to help him. I really enjoyed the work."

But an interest in science led him to the University of Akron — where he received his undergraduate degree in natural science — and, eventually, to NEOUCOM.

"There was a lot of competition to get into the school," Crow says. As he points out, NEOUCOM's six-year combined undergraduate-medical degree program has a lot of appeal.

"It's popular because once you're admitted (usually straight from high school), you're actually in medical school and you don't have the usual stresses and competition you get in a regular pre-med program."

Cost is a problem, he admits, but one that, so far, he's been able to handle.

"I'm paying about $6,000 a year for my education, which really isn't bad," he says, citing that the relatively low tuition costs is another reason why NEOUCOM is so popular.

"I may be unusual, but I've been able to handle the costs myself, through personal arrangements. I haven't had to go outside for financing the way a lot of medical students do."

Although Crow says that NEOUCOM is covering the subject of medicine quite well, he says that most of his exposure to socioeconomic issues, like health-care costs and ethics, has been through the OSMA.

"Of course, the school has recently reduced about 20% of our hours to allow us more free time," says Crow, in way of explanation. Still, he says, most of that has been in the form of busy-work, and not course-work.

"Where we used to do two of one thing, now we do just one."

Crow hopes to eventually open a single practice, or go into a small group practice — but it doesn't really matter where.

"I don't know whether I will stay in northeast Ohio or not. It will probably depend on where I take my residency," he says. "I want to go into pediatric surgery and there aren't that many opportunities for pediatric surgeons in the smaller northeastern communities."

But he's not about to exclude them.

"If Akron Children's gave me a call, I'd go. I'm not hung up on practicing in the big communities."

Nor is he overly concerned with the money he'll be making.

"Yeah, there is good money in medicine. It may not be as good as it used to be, but doctors will always be paid more than Joe Citizen. Still, surgeons don't make as much money as other specialists. If I were in it for the money, I would have chosen a different specialty."

As it is, he says, he will be dependent on referrals from his colleagues.

"That's why the type of practice I enter is not that important to me."

Crow is realistic about his future, and the future of medicine.

"I think I'll be able to make a comfortable existence for myself and my family (Crow is married, and he and his wife have recently adopted a seven-year old child), but I know there will be problems ahead. Not just for myself, but for medicine."

The technological breakthroughs which medicine is making will lead, inevitably, to more and more cost problems — and to more and more ethical/moral problems.

"I feel closer to the ethical issues," he says, "But I can't even pretend I know how to solve them."

Judith Lavrich,
University of Cincinnati School of Medicine



"Some women in my class are afraid that becoming a doctor means they won't be able to have a family, to have children," says Judith Lavrich, a 24-year-old junior at the University of Cincinnati School of Medicine. "I just laugh, because I know that's not true. My mother is a doctor, and she raised five of us. And I'm sure it's much easier for women to handle both a career and a family today than it was twenty years ago."

Today, Lavrich is looking forward to the challenge of her own life as a woman physician. "My mother was a terrific role model," she says, explaining both parents worked as pediatricians while she was growing up and her mother has since become an internist.

Lavrich, herself, is more interested in ophthalmology at this point, although "I'm keeping my mind open," she says. "I haven't yet been through the clinical years. I probably will stick with it (ophthalmology), though. It's a very challenging, high-tech field. I'm very interested in the eye, in general."

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Lavrich has been interested in a career in medicine since she was five years old, although she maintains she was not pushed into it by her physician parents. "I'm the only one of five children who's gone into medicine," she says. Because she excelled in math and science in high school, she looked at some other career possibilities, as well. "I looked at engineering and a lot of other areas," she says. But it was the people aspect of medicine that drew her back to her original career choice.

What she hopes to gain from that choice is the "personal gratification and fulfillment that comes from working with people in a scientific field that I feel challenged by and competent in," she says.

After earning a BS in Chemistry from the University of Toledo, the Cleveland native was accepted at a number of Ohio's medical schools, but she chose the University of Cincinnati because "it tries to incorporate a lot of out-of-state residents and people from varied backgrounds into its program. Many students already have earned advanced degrees. There are a wide variety of people in your classes, and you can learn a lot from all of them."

Cincinnati also has a strong reputation for its clinical educational program, she says. "We've just started our first rotations," she says, "but already we're getting a lot of attention and a lot of feedback."

Working in hospitals has also "made us aware of DRGs — slowly but surely," she says, although there is nothing formal in the medical curriculum to warn them about the changing face of medicine. "It's such a new thing for everyone, I'm afraid medical students are going to be among the last to learn about them, and that's too bad."

The school also attempts to make doctors-to-be aware of the legal, ethical and social issues they will be facing in their profession, Lavrich says, although most courses of this nature are electives. "There is an elective luncheon section where a lawyer comes in weekly to speak on legal and ethical issues," she explains. "There is also a Human Awareness elective that deals a lot with interprofessional relationships — how doctors, nurses, pharmacists work together to make ethical decisions."

Lavrich took advantage of the latter class and found it not only interesting but enlightening. "We took a hypothetical situation, such as there is only one dialysis machine available and several patients who need it. We then all had to decide together who was going to get the treatment."

Another particularly helpful group is a Women in Medicine section that meets to discuss not only women's issues, but also those surrounding physician lifestyle, stress management, etc. "It's both an information and a support group," she says.

Although some 33% of her medical school class is female, Lavrich comments, "being a woman has not really been an issue at my school. We're all treated very well here. I've not seen a whole lot of discrimination. I've been warned that once we get into our clinical rotations we may have some problems, particularly with the older doctors who are not used to having women in their profession. But so far, I haven't seen it."

Like her parents, Lavrich hopes to go into a partnership with another physician after she finishes her medical school and residency programs. She realizes, however, that options for size and type of practice — like the financial aspects of medicine — are changing, dramatically. "This could affect the positions medicine has open for doctors in the future," she says. "Things are changing drastically and will keep on changing — unless physicians start doing something about it."

She points to the recent implementation of Diagnosis Related Groups (DRGs) as a prime example. "In essence, DRGs are good, because cost-effective medicine is to everyone's benefit," she says. "But I'm beginning to wonder if government isn't getting too great a hand in medicine, and I'm not sure that's such a good thing. And the fact that DRGs came in so quickly, without a lot of outcry or rebellion, really scares me. I'm afraid most physicians just aren't aware of what they can do.

"Too many doctors are too wrapped up in medicine and their own practices. What they don't understand is they need to look beyond medicine, because so much is happening out there. And eventually, it's going to impact on the way they practice medicine."

Stephen Grable, Wright State University

"I definitely think that unless something is done about the cost (of a medical school education), a lot of people who would make good doctors won't be able to go to medical school," says Stephen Grable, a 27-year-old medical school senior at Wright State University.

When Grable started at Wright State three years ago, his tuition cost him $840 a quarter, he says. Following two tuition increases, it is now $1,907 a quarter. Like most medical students in Ohio, he will leave school with a substantial amount of debt when he graduates next spring.

But while that debt causes him some worry, he is more concerned about those students who may never make it into medical school at all. "You can deal with all of the other problems," he says. "But if you don't have the bucks, you aren't going to make it. Eventually, medicine will become a rich man's profession."

A native of Buffalo, New York, Grable earned a BS in Chemistry from the University of Florida and worked a year in a hospital in Canton, Ohio, before being admitted to Wright State. Today, he is depending upon both personal and government loans to get him through school — and adding up debts he knows will take a heavy toll on his income his first several years in practice.

"One of the problems with that much debt is that you really have to think about it in terms of your future," he says. "You can't even entertain the thought of a career change, because you have all of this debt to pay off. Many students end up feeling really trapped."

A large amount of financial debt can also affect a medical student's choice of specialty, Grable admits. Yet from his own point of view, "It's more important that you do what you really want to do. The debts will get paid eventually, one way or the other."

For Grable, doing what he wants is becoming an orthopedic surgeon. "I just fell in love with it," he says, after having completed a number of medical school rotations. "And the number-one thing for me was to pick a specialty I would enjoy doing. I pretended it was Sunday evening, and I asked myself, how hard was it going to be for me to go into work the next day. Would I look forward to it, or would I dread it?"

Grable realizes, however, that orthopedics is an extremely competitive field and that the market for orthopedic surgeons is tight. He also realizes that practice conditions for him and his fellow medical school graduates may be less than ideal when he completes his residency program in a few years.

"A lot of changes are coming in medicine," he says. "When I look at my future, I have to consider these, too. I want to be independent — but being independent is no longer a realistic goal. That is not necessarily something that I like, but with all that's happening in medicine — HMOs, DRGs — I think you have to be in a group to make a financial go of it.

"I would like not to have to think about the money, but medicine is becoming so much of a business that the people aspects are being forgotten. I have no aversion to large group care, if people are getting *good* care. But if it's run like a mill, I don't want any part of it. I truly believe that the minute the quality of care goes down, we've lost it."

Unlike some other schools in Ohio, Wright State does offer a number of seminars and lectures on the financial aspects of practicing medicine, according to Grable, although he adds, "I'm not sure we get enough of it. We definitely will need more knowledge before we go into practice."

Freshmen, in particular, are given some exposure to the changes occurring in the medical profession. "But as freshmen, you're so idealistic — things tend to go in one ear and out the other. You just want to stay in school and get a good education. Then, when you get into your third and fourth years, you begin to worry about all of these changes. And I'm sure we won't realize the full impact of it until it hits our pockets."

Like physicians in practice, medical students require a strong support structure and good coping skills in order to succeed, says Grable. And the pressure and stress that go along with the demanding schedule take their toll.

"It doesn't surprise me that there's as much of a drug and alcohol abuse problem as there is today among physicians," Grable says. "The further I get along in this, the more I can see it."

Fortunately, Wright State is also pretty progressive in its treatment of these complex problems. The school offers Freshmen and Sophomores "mini courses" or two-week electives on a number of topics related to physician lifestyle management, including stress and drug and alcohol abuse, he says. "Also, if you need any counseling or help, it's readily available," Grable says.

While Grable is in hopes that students interested in medicine can continue to gain admittance to Ohio's medical schools — regardless of their financial backgrounds — he is not opposed to some careful screening of applicants. Already, he says, the number of medical school applications is beginning to decline, due chiefly to better advising on the undergraduate level.

Because the medical profession is likely to continue to undergo dramatic changes over the next several years, "In selecting candidates, it's important to see if the applicant has a good attitude towards medicine in general," he says.

While medical students both today and tomorrow will most likely have to take the business aspects of their profession as seriously as the scientific, ethical and social aspects, he feels most will be up to the task.

"Medical students in general are very competitive people," he says. "They have had to compete successfully to get into school, and they are used to competition. For us, it will be a matter of compete or starve."

He is not, however, completely satisfied with that prognosis. "Personally, I would rather worry about the patients than the competition," he says. "My real hope is that we will be able to accept the reality of it all, yet still maintain our idealism."

William Todia, Medical College of Ohio, Toledo

"Financially, I expect to be comfortable, but if you want to make a lot of money, medicine isn't the place to be," says William Todia who will graduate next spring from the Medical College of Ohio at Toledo. "Especially when you consider the amount of time and money you have to put into it; if I wanted to make a lot of money, I'd be somewhere else."

Todia, however, a 25-year-old senior, is exactly where he wants to be. The Strongsville, Ohio native earned his undergraduate degree from the College of Wooster and completed a year of schooling in optometry at the Ohio State University before discovering that field was too limited for his interests and abilities. "I liked optometry, but I got the feeling that I'd be bored 10 years from now," he says.

Ophthalmology, on the other hand, offered both "an intellectual challenge" and emotional satisfaction. "I have a need to feel like I'm doing something constructive for people with my life," Todia says. "Medicine fills that need."

The road to a career in medicine, however, is not an easy one, Todia admits. Along with debts which will total him some $25,000 when he leaves school, Todia says students also accumulate a good deal of stress before they earn their MD degrees. "We worry mostly about getting

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through school," he says. "At first, it's just passing and making it through the first two years. Then there are the clinicals. And then it becomes, 'Am I good enough — will I know enough and be competent enough to be a good doctor?"

Finally, he says, in the last year of medical school, students struggle over their choices of specialties. This last year is the most stressful of all four years, he says. "When I get together with my classmates, this is what we talk about. It's a real consideration. Where do I want to go? What do I want to do? It's like graduating from college all over again — what am I going to do with my life? For me, this is more stressful than any of the money or financial problems."

Unfortunately, the stresses are only beginning for Todia and his fellow students. Medicine is changing, and, as Todia sees it, "The lines are being drawn for a battle. Industry, government and the public in general are no longer willing to pay the price for 100% of all the care we can give them. They are saying that, financially, we will pay only x number of dollars for x amount of care. If you want to go further, you'll have to pay for it yourselves."

Todia sees a rough road ahead for medicine over the next 20 years before — eventually — everyone will again receive treatment, although at different levels. "First the hospitals will pick up the extra cost, but that can only last for a short period of time," he predicts. "Eventually it will come down to the relatives and the physician — and the real judgment calls will have to be made by the physician."

As a result, Todia foresees a "rationing of care" in the future of medicine. He also predicts the rebirth of charity hospitals. "These will operate largely through donations from churches and other charitable organizations. They will serve the indigent and those with no insurance. If you can't afford to pay, you'll go there and take whatever care they can provide."

Meanwhile, in the interim, doctors, he says, will be forced to make some extremely difficult decisions. "It's the physicians who will be stuck on the review boards, the physicians who are forced to deal with the patients. We will be right in the middle. And we will know that we could do more, but that our hands are tied."

But his outlook for the future is not totally pessimistic. "If we realize this is happening now, we can make some suggestions — try to make this a painless transition. We, as doctors, can begin making some of the decisions now, rather than waiting for the head of SOHIO to tell us their bills are too high so this is the way it's going to be."

Todia continues, "Doctors need to make some decisions now. We need to ask ourselves, are we going too far with this particular treatment? Where do we need to cut back? Where can we draw the line? If we can come up with our own ideas, we can begin to make some reasonable cutbacks and still provide good care. In that way, the next 20 years could be really exciting for medicine."

Medicine is changing, and as Todia sees it, "The lines are being drawn for a battle." But his outlook is not totally pessimistic. "If we realize this is happening we can make some suggestions."

Todia has gained his futuristic perspectives chiefly through his involvement as a student delegate to both the American Medical Association (AMA) and the Ohio State Medical Association (OSMA). There is little in his medical school curriculum to warn him of the changes coming in the environment of medicine, he says.

"There are no special medical economics classes — no hospital utilization or cost awareness classes in our school," he says. "We're supposed to be getting that through our clerkships. But there's nothing formal, no emphasis in the teaching hospitals on what's going on in medicine — how we can do things differently or more cost effectively."

Some changes may be on the horizon, however. The AMA student delegation recently asked that organization to develop a curriculum packet on the economic aspects of medicine, including cost effectiveness and utilization, to be made available to medical schools throughout the country.

While Todia is grateful for the strong clinical and scientific academic background and training he is receiving at Medical College of Ohio, he also notes that classes on physician lifestyle are missing from the curriculum, as well, particularly stress management and the sometimes related problems of drug and alcohol abuse. "We do get some of this in courses in nutrition education, psychiatry and family medicine," he says. Also counseling and group therapy are available to students with problems.

"In our curriculum we spend a pretty decent amount of time talking about the disease of drug and alcohol abuse — but not from the angle 'is this happening to you?' Not how it relates to us personally."

A number of medical students, Todia says, are drug and alcohol users. But they are used not so much for stress as a release from boredom, he believes. "We spend so much time studying, taking tests, in the classroom — I get the feeling people are doing it more as a release than as a coverup for stress."

Todia, on the other hand, has developed other ways to alleviate boredom and relax after a long day in class or a long night at the hospital. For the past two years, he has worked in his spare time as an independent carpenter, contractor and painter, building windowboxes, decks, and supervising other home improvement

projects. He enjoys music and played second violin in the Wooster Symphony Orchestra and was an active member of the Wooster Concert Choir. He also played the lead role in two musical theatrical productions at his college, and was musical director of the Wooster Newman Club. In addition, he has been politically active, serving not only as a student delegate to the AMA and OSMA, but also on numerous OSMA student-oriented committees.

"Ophthalmology is a neat area — I'm looking forward to having a neat job — but it's still just a job . . ."

He plans to continue to develop his diverse interests even after he is out of medical school and has become a practicing physician. Ideally, he says, he would like to share a practice with two or three other physicians.

"I like to work hard when I work, but I have a lot of other interests, too," he says. "I may end up doing a lot of work during the week, but then I'll take a long weekend and do other things. Or if I have to work evenings and weekends, I'll take time off during the week. I have no intention of working 12 hours a day *and* Saturdays and Sundays. Ophthalmology is a neat area — I'm looking forward to having a neat job — but it's still just a job." **OSMA**

Karen S. Edwards is Executive Editor of the Ohio State Medical Journal.

Susan Porter is Assistant Editor of the Ohio State Medical Journal.

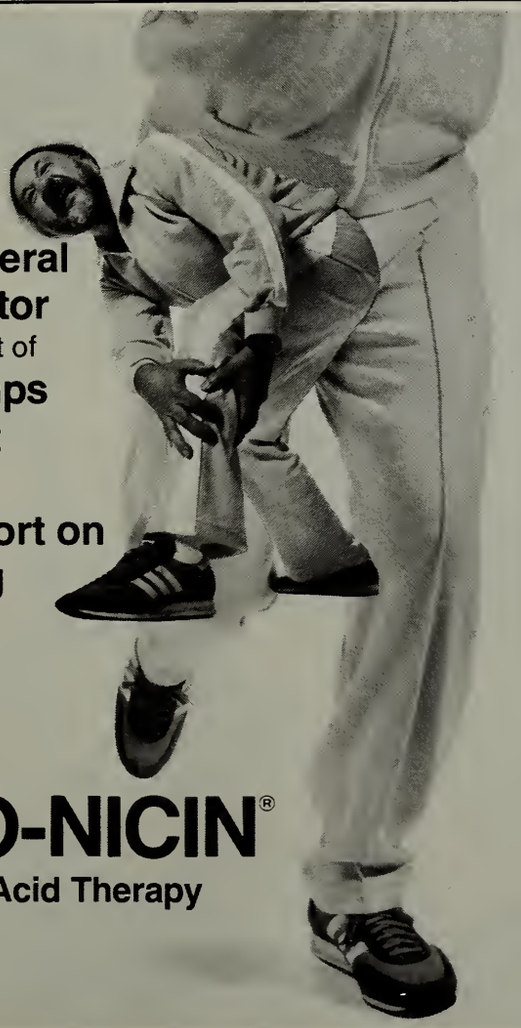
Young doctors likely to spurn solo practice

Young doctors are less likely to be self-employed than their older colleagues and, if self-employed, are more likely to be part of a group practice, says a survey, recently conducted by the AMA.

The survey of more than 2,000 doctors found that 61% of doctors less than 36 years old are self-employed, compared with percentages in the high 70s and low 80s for older physicians.

The younger doctors are choosing to work for hospitals and the government. The rate of self-employment is highest among general practitioners (83% of GPs surveyed) and lowest (68%) among those specialists whose skills are traditionally used in hospitals.

The survey also found that 48.9% of respondents were still in solo practice, compared with 54.2% in a 1975 survey.



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Medical Education:

Who Pays the Bill?

By Doug Evans

The annual cost of educating medical students in Ohio is enormous. It requires literally tens of millions of dollars for each of the seven institutions to operate, and it's obvious that none can survive on tuition alone. Funds generated through a variety of sources maintain the schools' diverse activities; but it is money granted by the state's Board of Regents, your tax dollars, that is the mainstay of survival.

The report states that the annual average cost of a medical education in Ohio is $43,872.

According to the 1983 *Report on Physician Manpower in Ohio: Requirements, Supply and Cost*, the Ohio Board of Regents reported that direct subsidies to state medical schools totalled 53% of each student's education for the year.

The report states that the average annual cost of a medical education in Ohio is $43,872 (1975 cost of $24,647 multiplied by an inflation adjustment of 1.780), and state subsidies equalled $22,750 per full-time student in 1983. If no additional inflation factors or capital costs are assumed, it is figured that "Ohio taxpayers will spend $91,000 per graduate in direct subsidies" for a four-year term.

However, as stated, these figures are an average, and the actual amounts and the percentage of operating budgets that the subsidies cover vary from school to school. John Minnick, Director of Budget for the Medical College of Ohio at Toledo, reports that state subsidies pay approximately 60% of the school's budget, while

The Cost of Oversupply

The cost of educating medical school graduates which may eventually lend to the state's physician oversupply problem could cost Ohio taxpayers more than $50 million by 1985.

The Ohio Board of Regents 1983 *Report on Physician Manpower in Ohio: Requirements, Supply and Costs* states that "if oversupply is defined as graduates in excess of physicians needed (in the state), then there would appear to be approximately 600 physicians per year in excess" by 1985. Taking into account that state supplements of medical schools are on an average of $91,000 per graduate over a four-year period, the cost of educating an oversupply of 600 physicians would be $54.6 million.

The need for physicians in Ohio will be approximately 364 in 1985, according to the Board of Regents. This calculation takes into account changes in population, rate of retirement of physicians and the need to maintain a physician-to-patient ratio of 1:2500 in primary care and 1:1000 in non-primary care. However, the graduation rate from the state's seven medical schools will exceed 1,000 per year by 1985, thus creating an excess of over 600.

Another problem that is addressed is that of the maldistribution of physicians around the state. The above calculation was made while taking into account that 420 physician graduates will satisfy the maldistribution situation and approximately 390 new physicians each year will keep it in balance. If medical school graduates do not choose to practice in areas of low-supply, the medical schools will be graduating physicians in a greater excess than previously assumed.

Another factor that the report does not take into consideration is that there seems to be a continual influx of out-of-state and foreign physicians to Ohio which also compounds the oversupply problem and, thus, increases the amount of dollars spent every year to educate more physicians than the state needs.

To this end, the report concludes that "at the time of limited state resources and a consequent weakening of program quality, the Board of Regents suggests there is an urgent need to review the projected need of physicians among the state's priorities. In the case of medical education, this would mean enhancing funding per student and the quality of education for reduced enrollment levels."

The recommendation that the Board of Regents makes to remedy the state's physician oversupply dilemma is to change the medical schools' admission, distribution, licensing and residencies to conform with a state policy which will relate to manpower needs. This policy will be established by a unit of state government according to population, geographic and socio-economic problems, and will assist underserved communities in locating and retaining qualified physicians. *DE*

Who Pays the Bill?

continued from previous page

Robert Daniels, MD, Dean of the University of Cincinnati Medical School, says that only 20% of the U.C. Medical School budget is met with state money.

To compensate for the remaining annual expenditures, the seven state medical schools receive monies from non-profit health organizations, private research grants and contracts, and endowments and contributions, along with tuition payments. Although most of the grant and contract money is restricted to specific areas of expenditures, it covers many of the costs of operating the programs at the medical schools. In some instances, as with the University of Cincinnati Medical School, many of the faculty members' (approx. 100 to 125) salaries are paid by outside organizations, according to Dr. Daniels.

However, in spite of the continuing effort to uncover new and more diverse forms of funding, state aid remains the backbone of the medical schools' financial stability.

According to Mike Tootell, Administrator of Health Programs for the Ohio Board of Regents, the state's seven medical schools receive funding according to criteria in five different categories, including instructional subsidies, clinical subsidies, and family practice, primary care and geriatric care programs. The four, newly established schools in the state: Medical College of Ohio at Toledo, Northeast Ohio Universities College of

1983 STATE MEDICAL SCHOOL SUPPORT

	INSTR. SUBSIDY	CLINICAL SUBSIDY	FAMILY PRACTICE	PRIMARY CARE	GERIATRIC MEDICINE	1983 TOTAL	PER STUDENT
Case Western	$ 4,530,125	$ NA	$639,944	$487,052	$129,469	$ 5,786,590	$ 8,386
Univ. of Cincinnati	9,460,950	4,256,764	560,898	351,821	127,582	14,758,015	16,828
Medical College of Ohio	6,901,011	3,604,128	682,846	337,166	130,547	11,655,698	23,274
NEOUCOM	3,853,599	280,636	781,170	327,094	129,469	5,371,968	23,836
Ohio State	10,310,737	11,605,470	764,552	359,878	127,582	23,168,219	23,909
Ohio Univ.	3,337,997	209,175	936,019	273,474	125,424	4,882,089	21,993
Wright State	4,664,256	385,225	781,170	327,094	129,469	6,287,214	18,737

Medicine, Ohio University School of Osteopathic Medicine and Wright State University, also received a special developmental subsidy from 1974 through 1983.

The instructional subsidy aid is granted according to necessary costs budgeted by the schools. These expenditures are to maintain the physical operations of the institutions as well as pay salaries of the personnel. Included in the budgets are the costs of faculty support, administrative support, other personnel, libraries and actual cost per square foot of the classrooms, labs and offices, according to Tootell.

A clinical subsidy is granted to the state institutions that maintain on-site hospitals and/or clinics for student training, says Tootell. The Board of Regents has an actual "per student value" for the facilities and training at each of the medical schools at Ohio State University, University of Cincinnati and the Medical College of Ohio at Toledo. The remaining schools, except for Case Western Reserve Medical School, receive a subsidy that is approximately 70% of the amounts granted to the above institutions. Case Western Reserve does not participate in the clinical subsidy program.

The total state medical school grant in Ohio in 1983 was $71,909,793.

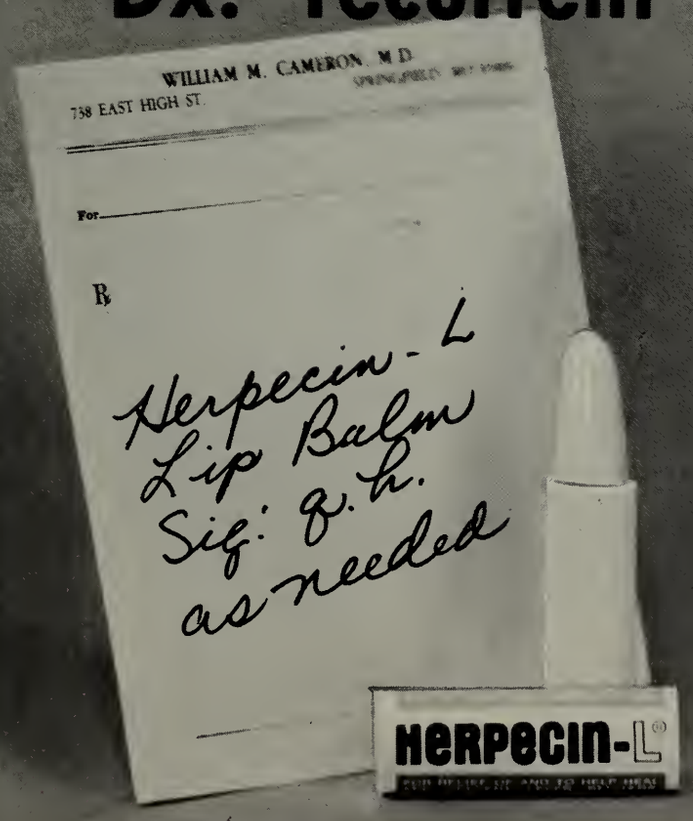
The family practice, primary care and geriatric medicine program subsidy amounts are determined by the Board of Regents, according to recommendations after personal interviews with the college deans, chancellors and university presidents, says Tootell. The Board of Regents makes an assessment of each school's needs and recommends the allotments to the state Office of Budget and Management in order to prepare the issue for the Ohio Legislature. In an effort to assure that the schools' needs are met, the deans often testify before the legislature on behalf of their programs, Tootell says.

Below is a chart which illustrates the varying degrees of support each state medical school receives, according to the different programs in 1983 and a comparison of the per student allotments.

The total state medical school grant in Ohio in 1983 was $71,909,793 as compared to the 1978 total allotment of $46,677,479. (None of these figures include the developmental subsidy granted to the Medical College of

continued on page 680

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The 1984 Annual Meeting Proceedings of the OSMA House of Delegates

Minutes of the First Session

The first session of the House of Delegates of the Ohio State Medical Association was convened at 7 PM, Friday, May 18, 1984, at the Cincinnati Convention Center, with the President, S. Baird Pfahl, Jr., M.D., presiding.

The invocation was offered by Dr. David A. Pack, Ironton.

Dr. Pfahl introduced Goodwin Berquist, Ph.D., Department of Communications, The Ohio State University, the parliamentarian retained in accordance with Resolution No. 1-76.

Dr. William H. Gates, Cincinnati, President of the Academy of Medicine of Cincinnati, welcomed the delegates, alternates and guests to Cincinnati.

1983 Minutes Approved

The minutes of the 1983 sessions of the House of Delegates, as published in the July 1983 issue of the Ohio State Medical Journal, were approved by official action.

1984 Special Session Minutes Approved

The minutes of the 1984 special session of the House of Delegates, held April 14, 1984, were approved by official action.

OMERF Report

Dr. Oscar W. Clarke, Gallipolis, Chairman of the Ohio Medical Education and Research Foundation, was introduced. Dr. Clarke explained this project and asked for the support of the OSMA members.

PACO Report

Dr. Herman I. Abromowitz, Dayton, Chairman of the Board of Physicians Administrative Corporation of Ohio, was introduced. Dr. Abromowitz gave a report on the current status of the company and a summary of the activities and accomplishments of PACO in 1983-84. Future plans were also discussed.

PICO Report

Dr. John J. Gaughan, Cleveland, Chairman of the Board of Physicians Insurance Company of Ohio, was introduced. Dr. Gaughan gave a report on the activities of the company since its beginning and he reported on future plans.

Introduction of Those at Speakers' Table

Dr. Pfahl introduced others seated at the speakers' table who had not been previously introduced, as follows: C. Douglass Ford, M.D., Immediate Past President; A. Burton Payne, M.D., President-Elect; David A. Barr, M.D., Secretary-Treasurer; James E. Pohlman, Esq., OSMA Legal Counsel; D. Brent Mulgrew, Esq., OSMA Staff Counsel; and Hart F. Page, CAE, Executive Director.

Introduction of AMA Board of Trustees Member

Dr. Pfahl introduced W.J. Lewis, M.D., Member of the AMA Board of Trustees. Dr. Lewis addressed the House.

Dr. Pfahl announced that Steve Ellwing, AMA Field Representative, was also in attendance.

Report of the Credentials Committee

Dr. Luther W. High, Millersburg, Chairman of the Credentials Committee, reported that of 230 members eligible to attend and vote, 164 were present, credentialed and seated. He also announced that included in this number were 16 specialty society delegates who qualified for representation under Chapter 4, Section 3, of the OSMA Bylaws. The Medical Student Section also was represented.

A number of alternate delegates, guests, officers of county medical societies, and executives were in attendance.

Introduction of OSMA Past Presidents

Dr. Pfahl introduced the following Past Presidents of the Association: Dr. Carl A. Lincke, Carrollton; Dr. Charles L. Hudson, Bratenahl; Dr. Richard L. Meiling, Columbus; Dr. Robert E. Howard, Cincinnati; Dr. Theodore L. Light, Dayton; Dr. Oscar W. Clarke, Gallipolis; Dr. James L. Henry, Grove City; Dr. John J. Gaughan, Cleveland; Dr. Thomas W. Morgan, Gallipolis; Dr. Stewart B. Dunsker, Cincinnati; and Dr. C. Douglass Ford, Toledo.

Introduction of Past Members of the OSMA Council

Dr. Pfahl then introduced former members of the Council: Dr. Theodore J. Castele, Cleveland; Dr. Alford C. Diller, Van Wert; Dr. William Dorner, Jr., Akron; Dr. Philip B. Hardymon, Columbus; Dr. Stephen P. Hogg, Cincinnati; Dr. Edward G. Kilroy, Cleveland; Dr. W.J. Lewis, Dayton; Dr. George Newton Spears, Portsmouth; and Dr. J. Hutchison Williams, Columbus.

Introduction of OSMA Auxiliary President

Mrs. Stella Brown, Dayton, Immediate Past President of the Ohio State Medical Association Auxiliary, was escorted to the podium by Dr. Herman I. Abromowitz. She addressed the House of Delegates and reported on 1983-84 activities of the Auxiliary.

Distinguished Service Citations

Dr. Pfahl asked Mrs. Perry R. Ayres to come forward to accept the Distinguished Service Citation on behalf of her late husband. Mrs. Ayres was escorted to the podium by Dr. H. William Porterfield. Dr. Pfahl read the following resolution to the House of Delegates:

Whereas, the late Perry R. Ayres, M.D., served for many years as a successful internist, and as editor of the *Ohio State Medical Journal;* and

Whereas, Dr. Ayres became seriously impaired by substance abuse, lost his practice, and nearly lost his life; and

Whereas, through a combination of personal courage and helping hands from family, friends, and fellow physicians, Dr. Ayres made a full recovery and re-entered the practice of internal medicine; and

Whereas, Dr. Ayres became chairman of the OSMA Committee on Impaired Physicians and the Physician Effectiveness Program (PEP) following the death of Milton M. Parker, M.D., in March, 1978; and

Whereas, Dr. Ayres participated on the faculty of several national and international impaired physician conferences, as well as appearing before county medical societies,

continued from previous page

hospital staffs, and physicians-in-training; and

Whereas, through the dynamic leadership of Dr. Ayres from 1978 until his untimely passing in May, 1983, PEP became one of the outstanding assistance programs for professionals in the nation; therefore be it

RESOLVED, that the Ohio State Medical Association expresses its deepest respect and admiration for this physician who exemplified on a daily basis "I Am My Brother's Keeper;" and be it further

RESOLVED, that the memory of Dr. Ayres, who dedicated his life to helping not only impaired physicians, but also their families, in regaining a harmonious, productive, lifestyle, be honored by the presentation of an OSMA Distinguished Service Award to his family.

Dr. Payne then read the inscription on the plaque which was presented to Mrs. Ayres.

Dr. Pfahl also introduced members of the Ayres family who were in attendance.

Dr. Pfahl then asked Mrs. Milton M. Parker to come forward to accept the Distinguished Service Citation on behalf of her late husband. Mrs. Parker was escorted to the podium by Dr. J. Hutchison Williams and was accompanied by family members who were in attendance including a son Dr. Jeffrey D. Parker.

Dr. Pfahl read the following resolution to the House of Delegates:

Whereas, in the early 1970s, Milton M. Parker, M.D., Chairman of the OSMA Committee on Mental Health, recognized the need to help fellow physicians seriously ill from the effects of alcoholism, drug dependence, mental and emotional problems; and

Whereas, Dr. Parker organized the original Subcommittee on Impaired Physicians in 1975; and through his leadership the Physician Effectiveness Program (PEP) was structured; and

Whereas, Dr. Parker donated countless hours between 1975 and 1978 to speaking to county medical societies and hospital staffs to spread the good news that a helping hand was available from OSMA; and

Whereas, Dr. Parker encouraged recovering physicians in Ohio to actively participate in PEP — thus setting a pattern which has proven highly successful in programs throughout the nation for impaired professionals; and

Whereas, Dr. Parker saw the need for continuity, updating and growth in PEP, and therefore selected Perry R. Ayres, M.D. as assistant chairman shortly before his untimely death in 1978; therefore be it

RESOLVED, that the Ohio State Medical Association expresses its deepest appreciation for the pioneering efforts of Milton M. Parker, M.D. in organizing and providing outstanding leadership for the Physician Effectiveness Program; and be it further

RESOLVED, that the memory of this man who was so dedicated to helping his fellow physicians be honored by the presentation of an OSMA Distinguished Service Award to his family.

Dr. Payne then read the inscription on the plaque which was presented to Mrs. Parker.

Dr. Pfahl called for a vote on the resolutions and both were approved by a standing vote of the House.

AMA-ERF Checks Presented

Dr. Philip B. Hardymon, Columbus, Chairman of Ohio's Committee for the American Medical Association's Education and Research Foundation (AMA-ERF) was introduced, as was Mrs. Stella Brown. Mrs. Brown assisted Dr. Hardymon in the presentation of the AMA-ERF checks to Ohio's six medical schools.

It was announced that these contributions totaled $68,853.84.

Special Awards

Special certificates of appreciation were awarded as follows:

Dr. Pfahl announced that the first award was presented to Dr. John Burkhart, Columbus, for his service on the Ohio Occupational Therapy and Physical Therapy Board, Physical Therapy Section. Dr. Burkhart was escorted by Dr. Claire V. Wolfe to the podium. Dr. Pfahl read the following resolution to the House:

Whereas, John A. Burkhart, M.D., served as President of the Occupational Therapy and Physical Therapy Board from 1980 until 1983; and

Whereas, John Burkhart was one of the charter members of the Board when it was first established in 1977; and

Whereas, John Burkhart was, until this year, the only physician member of the Board; and

Whereas, John Burkhart strived during his tenure as President to promote and protect the public health through his diligence in promoting high standards and quality care among physical therapists and occupational therapists; and

Whereas, John Burkhart's efforts as President of the Board helped promote understanding and cooperation among physicians, physical therapists and occupational therapists; and

Whereas, John Burkhart gained the respect of both the physicians and the people he served, as evidenced by his election as President during three of his six year terms; now therefore be it

RESOLVED, that the Ohio State Medical Association commend John Burkhart for his dedicated service to medicine and to the public health; and be it further

RESOLVED, that this recognition be commemorated by presenting John Burkhart with a special citation from his colleagues in grateful appreciation of his commitment to the practice of medicine, its allied fields and the citizens of Ohio through his work as President of the Occupational Therapy and Physical Therapy Board.

Dr. Payne then read the inscription on the plaque.

The next special award was presented to Dr. Oscar W. Clarke, Gallipolis, for his service on the Ohio State Medical Board. Dr. Clarke was escorted to the podium by Dr. Thomas W. Morgan.

Dr. Pfahl read the following resolution to the House:

Whereas, Oscar W. Clarke, M.D., recently completed a seven-year term as a member, and a one-year term as President of the Ohio State Medical Board; and

Whereas, under his capable direction, the Board promoted and protected the public health by implementing and carrying out regulations to insure the quality of care provided by medical practitioners in the State of Ohio; and

Whereas, during the time that Oscar Clarke served on the Board, he also served on the committee charged with insuring that areas of limited practice maintained high standards of care; and

Whereas, Oscar Clarke devoted much of his time as a Board member to helping his troubled colleagues; and

Whereas, Oscar Clarke strived to promote the high ideals of the medical profession and to promote them publicly during his tenure as President; and

Whereas, Oscar Clarke has spent many years in dedicated service to the medical profession, not only as a member and President of the Ohio State Medical Board, but also by serving as President of the Ohio State Medical Association in 1973-74, Chairman of the Ohio Delegation to the American Medical Association House of Delegates since 1979 and as Chairman of the Ohio Medical Education and Research Foundation; therefore be it

RESOLVED, that the Ohio State Medical Association express its deepest respect and appreciation to Oscar W. Clarke, M.D., for his dedication to the medical profession and the public health; and be it further

RESOLVED, that this appreciation be commemorated by presenting Oscar Clarke with a special citation from his colleagues in grateful recognition of his commitment to medicine and the health of the citizens of Ohio through his work as President of the Ohio State Medical Board, 1983.

Dr. Payne then read the inscription on the plaque.

Both resolutions were approved by the House by a standing vote.

Certificates of Appreciation to Retiring Members of The Council

The following members of the Council received certificates of appreciation in honor of their service to the Association as members of the Council: Dr. C. Douglass Ford, Toledo; Dr. Edward G. Kilroy, Cleveland; and Dr. H. Judson Reamy, New Philadelphia.

Certificates of Appreciation

The following members of Standing Committees and chairmen of Special Committees of the Association received certificates of appreciation for past service:

Dr. Herman I. Abromowitz, Dayton, Chairman, Committee on Auditing and Appropriations; Dr. Stewart B. Dunsker, Cincinnati, Chairman, OSMA-ONA Liaison Committee; Dr. Carl E. Spragg, New Concord, Chairman, Committee on Education; Dr. Alford C. Diller, Van Wert, Chairman, Health Planning Advisory Panels Committee; Dr. John A. Devany, Toledo, Chairman, Committee on Coalitions for Planning; Dr. Richard J. Nowak, Cleveland, Chairman, Committee on Cost Effectiveness; Dr. H. Judson Reamy, New Philadelphia, Member, Committee on Auditing and Appropriations; and Dr. Carl E. Spragg, New Concord, Member, Committee on Program.

Medicaid Drug Formulary

Dr. Janet Bixel, Columbus, Delegate/Franklin County, asked to address the House. She advised that she is a member of the newly formed Drug Formulary Advisory Group of the Department of Public Welfare. This group was formed to review the current Medicaid Drug Formulary and make revisions. She asked for the support of members of the House in completing a survey to give input to this project. Copies of the survey were made available to the House.

Reference Committee Chairmen Announced

The following House of Delegates Reference Committee chairmen were introduced by President Pfahl:

Credentials of Delegates — Dr. Luther W. High, Holmes County; Tellers and Judges of Election — Dr. Claire V. Wolfe, Franklin County; Resolutions Committee No. 1 — Dr. Stanley J. Lucas, Hamilton; Resolutions Committee No. 2 — Dr. Joseph Sudimack, Jr., Trumbull County; Resolutions Committee No. 3 and President's Address — Dr. Richard J. Nowak, Cuyahoga County.

Several changes in committee personnel were announced.

Election of Committee on Nominations

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations: First District — Dr. Kenneth Frederick, Hamilton County; Second District — Dr. A. Robert Davies, Miami County; Third District — Dr. Alford C. Diller, Van Wert County; Fourth District — Dr. Roland A. Gandy, Jr., Lucas County; Fifth District — Dr. John J. Gaughan, Cuyahoga County; Sixth District — Dr. Raymond J. McMahon, Stark County; Seventh District — Dr. Jack M. Matheny, II, Monroe County; Eighth District — Dr. David L. Klein, Muskingum County; Ninth District — Dr. Oscar W. Clarke, Gallia County; Tenth District — Dr. James E. Matson, Franklin County; Eleventh District — Dr. James F. Clements, Richland County; Twelfth District — Dr. W. Paul Kilway, Jr., Summit County.

Dr. Pfahl announced that under the system of rotation approved by the House of Delegates in 1963, the chairman of the Committee this year would be the delegate from the Eleventh District, Dr. James F. Clements, Richland County.

Dr. Pfahl then announced to the House the OSMA Council position on voting for AMA Delegates and Alternate Delegates this year. Ohio is entitled to one additional Delegate and one additional Alternate-Delegate due to membership gain. The Council suggested that the House vote for one additional delegate, making the delegate count 15 and not vote for an additional alternate, making the alternate count 13.

President's Address

Hart F. Page introduced Dr. S. Baird Pfahl, Jr., who then gave his Presidential Address.

Upon completion of the presentation of the Address, Dr. Pfahl received a standing ovation.

Introduction of Out-of-State Guests

Dr. Pfahl introduced the following out-of-state guests: Dr. Robert C. Hamilton, Chicago, Illinois, President, Illinois State Medical Society; Dr. George T. Lukemeyer, Indianapolis, Indiana, President, Indiana State Medical Association, and Mrs. Lukemeyer; Dr. Donald C. Barton, Corbin, Kentucky, Chairman of the Board, Kentucky Medical Association; Dr. Louis R. Zako, Dearborn, Michigan, President, Michigan State Medical Society, and Mrs. Zako; Dr. Carl R. Adkins, Fayetteville, West Virginia, President, West Virginia State Medical Association, and Mrs. Adkins; Dr. Timothy T. Flaherty, Neenah, Wisconsin, President, State Medical Society of Wisconsin.

Introduction of Representatives of Allied Organizations

Dr. Pfahl introduced the following representatives of allied organizations: Bryan Rogers, Toledo, Chairman of the Board, Ohio Hospital Association, and Mrs. Rogers; Dr. Carmin Maietta, Columbus, President, Ohio Osteopathic Association, and Mrs. Maietta; Dr. Raymond A. Kiwala, Cleveland, President, Ohio Academy of Family Physicians, and Mrs. Kiwala; Dr. George E. Wright, Cincinnati, President, Ohio Veterinary Medical Association; Ms. Anna Mae Albert, CMA-A, Toledo, President, Ohio State Society of Medical Assistants. Also, Mrs. S. Baird Pfahl, Huron, newly-installed President; Mrs. Lance Talmage, Toledo, President-Elect, and Mrs. John R. Brown, Dayton, Immediate Past President, OSMA Auxiliary.

CON Task Force on Health Care Report

Dr. D. Ross Irons addressed the members of the House and gave an up-to-date report on the CON Task Force on Health Care for their information.

Introduction of Resolutions

Dr. Pfahl announced that because the resolutions had been printed and distributed to the members of the House prior to the meeting and the assignment of resolutions to the Resolutions Committees had also been presented to the House in writing, individual introduction of the resolutions would be waived unless there were objections voiced by the House. There were none and the reading of the resolutions was waived. He also announced that Resolutions 25-84 and 27-84 had been withdrawn by their sponsors. There were no objections and the resolutions were withdrawn.

Dr. D. Ross Irons asked that Resolution No. 20-84 be withdrawn, in addition. The request was granted.

Committee on Emergency Resolutions Report

The Committee on Emergency Resolutions reported that it had met earlier on May 18 to consider two emergency resolutions as follows: "Antitrust Immunity," introduced by the Sixth District Delegation; and "Special Meetings of the OSMA House of Delegates," introduced by the Summit County Medical Society.

It was the decision of the committee that neither met the criteria for the emergency resolution category.

The House concurred with the committee's report and the report was filed by action of the House.

Action Report on 1983 Resolutions

Dr. Pfahl announced that a report on the "follow-up" work on 1983 Resolutions had been distributed to the Delegates and Alternates prior to the First Session.

House Recessed

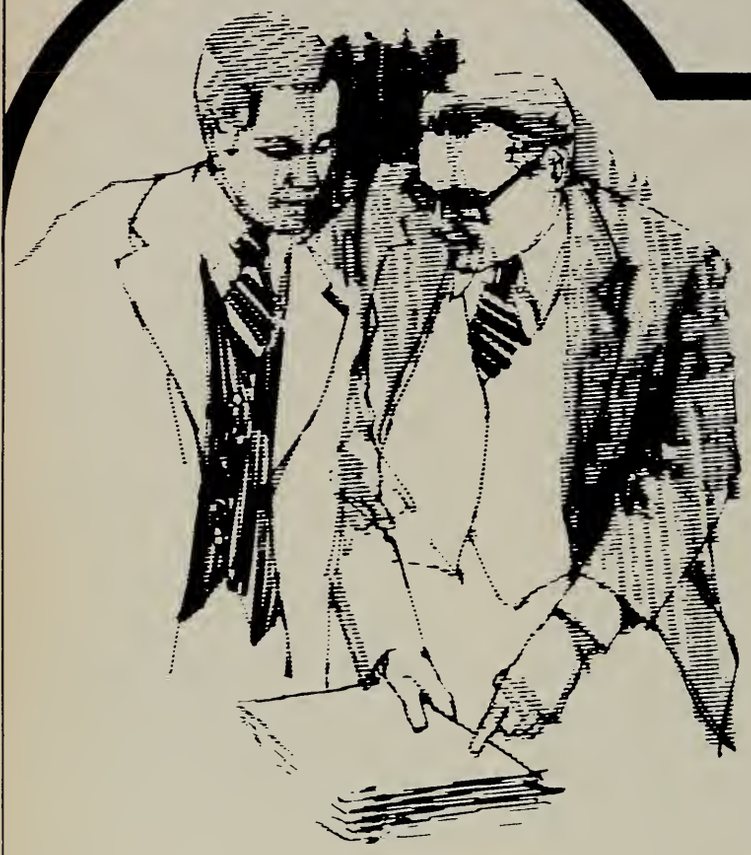
The House then recessed until the final session, 1:00 PM, Sunday, May 20.

The Minutes of the Second (Final) House will be published next month.

Switch

continued from page 649

12. Keettel WC: Discussion of studies in medical education: Career choice consistency of medical study by Donovan et al. Am J Obst Gynec 112:523-526, 1972
13. McAllister S, Brent EE: Changing perception of medical specialties: A factor of socialization. Ann Res Med Educ Conf, Assoc Am Med Coll, San Francisco, 1976
14. Oates RP, Feldman HA: Longitudinal study of career choices of a SUNY-Upstate cohort of medical students. J Comm Health 5:131-139, 1979



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Our Future in Medicine

By Nancy J. Cossler, MD

Editor's Note: The following essay was originally presented as a speech by the author, to her graduating class at the Northeastern Ohio Universities College of Medicine.

Before we can look to the future, I believe we must first seek an understanding of the past. We are, after all, the product of our collective past and like our knowledge, our hopes too, have been shaped by that past. Each generation arrives, in its time, with this cultural fund of values and knowledge, to which each adds their own unique perspectives and interpretations.

As a physician, I have profited from the labors of those who preceded me in medicine — from my teachers, and, through them, from their teachers. As a woman, I have profited from the ground work of women who, before me, believed that I belonged here. To all of these men and women, I owe my respect and my thanks. I have no illusions; I will not be as great as they were, but I am their inheritor, and I intend to send my profession forward, as they did. Each of you will likewise choose the shoulders you intend to stand upon; remembering that without their work, none of us would be here, and remembering also that each of us now has the opportunity and the obligation to further their work in our own perspective.

And so, what of our future in medicine?

Thomas Szasz, a radical thinker of his generation and a humanist in the finest sense, has said that medicine is an encounter with mankind. At its broadest, that encounter will surely be met if some of us seek to fill any of the great voids in medicine; whether in its knowledge or in its delivery to those it does not yet serve. But, we will not all be so clever or so gifted or find in ourselves such great callings. All of us, however, can make that encounter each day we practice if we remember that it is not health or disease which require our skills, but people. It has become cliched to speak of machines and instruments and numbers spewn forth from computers that separate physician from patient in a human sense; the erosion of that relationship is nevertheless real and the threat continues. Lewis Thomas has written: "If I were a medical student . . . just getting ready to begin, I would be more worried about this aspect of my future than anything else. I would be apprehensive that my job, caring for sick people, might soon be taken away, leaving me with quite the different occupation of looking after machines . . ." I hope we will find the means to answer this challenge and seek to preserve the subtle and uniquely personal relationship that is the essence of the encounter between physician and those who seek our help.

Medicine, as science, does not begin as we accept the title doctor; nor did it begin the day we put on our white coats and conspicuously hung our stethescopes about our necks. The science of medicine began with the pathways of amino acid synthesis and the pathology slides that never ended.

You have all heard the overworked expression: Medicine is both an art and a science. Overworked, no doubt, because it is absolutely true. Much of its art is found in the encounter, but the substance of that encounter is its science.

Medicine, as science, does not begin as we accept the title doctor; nor did it begin the day we put on our white coats and conspicuously hung our stethescopes about our necks. The

Our Future in Medicine

continued from previous page

science of medicine began — you all know when — with the pathways of amino acid synthesis, the dissection of the cranial nerves, and the pathology slides that never ended. And, as we each became involved in our own particular area of interest and the pathways were forgotten, the study of science continued through textbooks and conferences and journal articles. For us, as long as we are in the business of giving advice to others, the pursuit of the science of medicine can never end. We will not all practice this science in laboratories or in clinical studies, but we are all obligated to use it daily as we examine the works of others and decide which views we will adopt. A recent article, whose philosophy I support, put it this way: "It is not enough that one does what one believes is best; one must do what is in accord with sound scientific evidence. Ethical behavior alone is not sufficient to determine best treatment."

In the end, I suppose, it may seem that we are laid top-heavy with responsibility to preserve the art and science of medicine. But, such is the compromise of life's work: where the satisfactions and rewards are great, so too are the responsibilities.

Each of us will be free to choose the patterns of our work, the values we will fight for and the satisfactions we will treasure.

And, in silent rooms, each of us will be our own judge. **OSMA**

Nancy J. Cossler, MD, graduated from Northeastern Ohio Universities College of Medicine in May, 1983. She is currently in her second year of OB-GYN residency in Detroit, Michigan.

Who Pays the Bill?

continued from page 673

Ohio, NEOUCOM, Ohio University and Wright State University which totalled $10,585,755 in 1983 and $13,527,302 in 1978, or a grant of $86,219 to NEOUCOM in 1978 to educate Mexican medical students to qualify them for practice in the United States.)

The Ohio Board of Regents contends that the distribution of funds to the state's medical schools is best reflected in total funding rather than being based on undergraduate enrollment. The report states that high quality medical education programs are found in institutions with well-organized research endeavors, and funding from research contracts may support education. This funding may become more and more significant, as the report concludes that "adequate funding of seven medical schools at their current size will require more funds than are currently available."

Doug Evans is Editor of OSMA's patient publication **Synergy,** *and a staff writer for the* **OSMA Journal.**



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Obituaries

EDGAR S. BALL, MD, Tarpon Springs, Florida; University of Pittsburgh School of Medicine, Pittsburgh, 1944; age 69; died June 19, 1984; member OSMA and AMA.

ROGER L. BLACK, MD, Cleveland; State University of New York College of Medicine, 1946; age 60; died June 5, 1984; member OSMA and AMA.

ANTONIO S. BROGLIO, MD, Case Western Reserve University School of Medicine, 1932; age 77; died June 5, 1984; member OSMA and AMA.

ALEX N. JOHNS, MD, Toledo; University of Michigan Medical School, Ann Arbor, Michigan, 1929; age 81; died July 7, 1984; member OSMA and AMA.

ALBERT N. KLEINMAN, MD, Cleveland; Case Western Reserve University School of Medicine, 1950; age 61; died June 22, 1984; member OSMA and AMA.

MOSES LOEWENTHAL, MD, Cleveland; Friedrich-Wilhelms Universitat Medizijische Fakultat, Berlin, Germany, 1921; age 87; died May 15, 1984; member OSMA and AMA.

URSZULA ISABLE NITCH, MD, Pataskala; Medizinische Fakultat der Eberhard-Karis-Universitat Baden, Wurttenburg, Germany, 1949; age 66; died July 5, 1984; member OSMA and AMA.

JOSEPH A. RIDGEWAY, MD, Columbus; Ohio State University College of Medicine, 1938; age 72; died July 2, 1984; member OSMA.

JAMES E. ROSE, MD, Wilmington; Ohio State University College of Medicine, 1938; age 70; died June 21, 1984; member OSMA and AMA.

EUGENE J. WEBER, MD, Cleveland; University of Rochester School of Medicine, Rochester, New York, 1944; age 65; died June 26, 1984; member OSMA and AMA.

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Continuing Medical Education

September

NEPHROLOGY UPDATE — 1984: September 19-21; Bunts Auditorium, The Cleveland Clinic, 9500 Euclid Avenue; sponsor: The Cleveland Clinic Educational Foundation; 15 credit hours; fee: $200, $140 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

October

4TH ANNUAL RICHARD L. FULTON, M.D. MEMORIAL SEMINAR — ELEMENTS OF MALPRACTICE AND PRINCIPLES OF MALPRACTICE PREVENTION: October 9; Susan H. Edwards Auditorium, Riverside Hospital, Columbus; sponsor: Riverside Methodist Hospital, Columbus; 2 credit hours; no fee; contact: Linda Yoder, CME Coordinater, Riverside Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5468.

2ND ANNUAL NEONATAL CONFERENCE; NEONATAL/PERINATAL MONITORING: October 11; Hyatt Regency, Columbus; sponsor: Children's Hospital, Columbus; 6 credit hours; fee: $75; contact: Becky Martin, Education Department, 700 Children's Drive, Columbus 43205, phone: 614/461-2914.

MEDICAL UPDATE 1984: October 17; Harley Hotel, South, Independence, Ohio; sponsor: Department of Medicine, Cleveland Metropolitan General Hospital; cosponsor: Case Western Reserve University; 6 credit hours; no fee; contact: Neal V. Dawson, M.D., 3395 Scranton Road, Room H-331, Cleveland 44109, phone: 216/459-3902.

SEPTIC SHOCK: AN INTENSIVE CARE APPROACH: October 24; Fawcett Center For Tomorrow, 2400 Olentangy River Road, Columbus; 6 credit hours; fee: $75, $30 for nurses; contact: Linda Yoder, CME Coordinator, Riverside Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5468.

UROLOGY FOR THE NON-UROLOGIST: October 27; Stouffer's Inn on the Square, Cleveland; sponsor: Case Western Reserve University School of Medicine; 6 credit hours; fee: $50; contact: Division of Urology — Seminar, Case Western Reserve University School of Medicine, 2065 Adelbert Road, Cleveland 44106, phone: 216/844-3009.

November

ACHIEVEMENT OF NORMALCY IN THE CHRONICALLY ILL AND DISABLED CHILD AND ADOLESCENT: November 1; Christopher Inn, Columbus; sponsor: Children's Hospital, Columbus; 6 credit hours; fee: $35; contact: Becky Martin, Education Department, 700 Children's Drive, Columbus 43205, phone: 614/461-2914.

FOOD, DRUGS AND AGING: November 1-2; Hollenden House Hotel, Cleveland; sponsor: Center on Aging and Health, Case Western Reserve University; 12 credit hours; fee: $125; contact: Ruth E. Dunkle, Director, Center on Aging and Health, Case Western Reserve University, Cleveland 44106, phone: 216/368-2692.

THE DIAGNOSIS AND TREATMENT OF MUSCULOSKELETAL TUMORS: November 2; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 6 credit hours; fee: $75, $50 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

THE CRITICALLY ILL CHILD — URGENT AND EMERGENT PROBLEMS: November 7; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

MAKING THE VICTIM WHOLE AGAIN: AN INTERPROFESSIONAL APPROACH TO VIOLENCE: November 9; Hilton Inn North, Columbus; sponsor: Commission on Interprofessional Education and Practice, Ohio State University; cosponsor: Ohio State Medical Association; 6 credit hours; fee: $55; contact: Commission on Interprofessional Education and Practice, Mershon Center, 1712 Neil Avenue, Columbus 43210, phone: 614/422-5621.

GASTROENTEROLOGY UPDATE: November 14-15; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: $150, $100 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

FIFTH ANNUAL COLON & RECTAL SURGERY SYMPOSIUM: November 16-17; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: $200, $150 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

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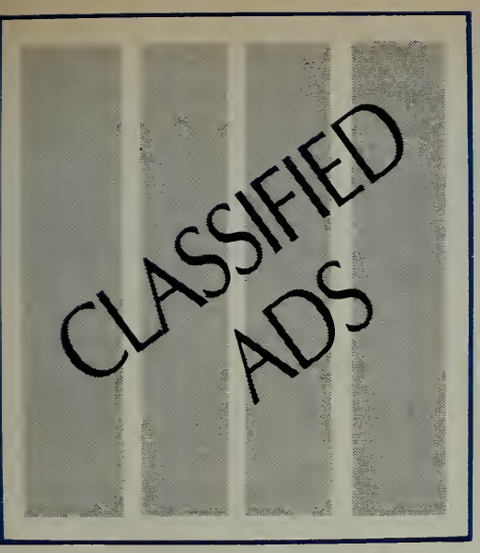
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GENERAL SURGICAL PRACTICE in Southeastern Ohio. A well established existing practice with general practice involved. Fully equipped office. Will introduce and remain a limited period of time. Reply to Box No. 29, c/o Ohio State Medical Journal, 600 S. High St., Columbus, OH 43215.

GENERAL SURGEON BC/BE: needed to work with two other general surgeons in well established surgical practice. Small, pleasant community in NW Ohio with well equipped 110-bed hospital. Reply to Box No. 24, c/o Ohio State Medical Journal, 600 South High Street, Columbus, OH 43215.

INDIANA — FAMILY PRACTITIONER to serve rural community in southeastern Indiana. Thirty five miles from Cincinnati, Ohio. New facility within 15 miles of full service hospital. Strong community support. Send resume to: F.W. Dayton, Rural Health Activities, 605 Wilson Creek Rd., Lawrenceburg, Indiana 47025.

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Assistant Health Commissioner position for a $13 million health department in the nation's 19th largest city. We are seeking an individual who will function as the chief medical spokesperson for the department, serving as liaison to the medical community and as medical consultant to department programs, including a comprehensive ambulatory care system, community home health services, immunization and well-child clinics, dental program, and WIC program. In addition, this individual will supervise the sexually transmitted disease, alcoholism and drug abuse, laboratory, and epidemiology programs. This position will also provide an opportunity for clinic and/or faculty affiliation with the Ohio State University School of Preventive Medicine.

Applicants must be licensed or eligible to be licensed to practice medicine in Ohio and must have one year's experience in a public health agency or possess a master's degree in public health or health-related field. Previous administrative experience desirable.

Salary established by Board of Health. Excellent fringe benefit package. For further information contact:
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(Planning and Administration)
Columbus Department of Health
181 Washington Boulevard
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It's Not Fun Anymore

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only going to reimburse you at 50% of the rate your other patients are charged, a 50% rate that just approximates your overhead, in family practice anyway. Then pick up a paper and find yourself maligned in the press for the excessive cost of healthcare. No, it's not fun anymore.

What about the future? I expect the future generations will not feel intimidated by this repression. If one grows up in a system such as this, it will be accepted because "that's the way it has always been." For those of us who remember the freedom to treat and the mutual respect between physician and patient, it will be difficult to see patients looking to their congressmen for their health care needs and for us to be looking to PPOs, the government and other institutions for our remuneration.

Enter at your own risk, young man. For all its satisfactions there are much less demanding occupations requiring little or no sacrifice of years of your youth or time from your family, and since we're criticized for it anyway, financially more rewarding for the time and responsibility required. No, it's really not fun anymore. **OSMA.**

Harold G. Kelso, Jr., MD, Dayton, is president of the Montgomery County Medical Society.

Malpractice focus of Fulton Lecture

The Fourth Annual Richard L. Fulton, MD, Memorial Lecture will take place October 9, 1984 in the Susan H. Edwards Auditorium at Riverside Hospital, Columbus, Ohio. Guest Lecturer, Thomas Gutheil, MD, Associate Professor, Psychiatry, Massachusetts Mental Health Center, Harvard Medical School, and a visiting lecturer from Harvard Law School will discuss "Elements of Malpractice" and "Principles of Malpractice Prevention." The lecture will begin at 7:30 a.m.

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OHIO (Central and Northern Areas): Seeking Emergency Medicine physicians for full time and locum tenens opportunities in attractive moderate volume facilities. Directorships also available. Competitive hourly rates, malpractice insurance and flexible scheduling. For more information contact: Emergency Consultants, Inc., 2240 S. Airport Road, Suite 128, Traverse City, MI 49684; 800-253-1795 or in Michigan 800-632-3496.

ORTHOPEDIC SURGEON & ENT NEEDED for town of 17,500 population and service area of over 50,000 in Northern Ohio. Progressive 18 man multi-specialty group. Close to 149 bed hospital. Minimum salary guarantee plus retirement and other fringe benefits including malpractice and life insurance paid. Excellent opportunity. For more information contact: Ken Williams, Jackson & Coker, 4488 N. Shallowford R., Suite 1040-Y, Atlanta, GA 30338 or call COLLECT (404) 393-1210.

PHYSICIAN WANTED. General office practice, small private clinic. Columbus, Ohio. 35 hrs. per week. $40,000 base salary — plus percentage. Prefer age 30 to 45 yrs. Reply with brief summary to Box No. 27, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

PSYCHIATRY — OB-GYN

Modern, well-equipped, 300 bed hospital, 30 miles east of Columbus in need of physicians for private practice of Psychiatry and OB-GYN. Documented need for board eligible or certified physicians in these specialties. For more information contact: Ralph Pickett, MD, 1-614-334-0331, Licking Memorial Hospital, 1320 West Main Street, Newark, Ohio 43055.

STAFF PSYCHIATRISTS

Immediate openings for staff psychiatrists for state operated 350 bed in-patient psychiatric hospital. Must be licensed to practice in the state of Ohio. Board eligible or Certified.
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Salary starts at $55,000.00 upwards according to experience, with excellent state fringe benefits.
Send resume to:

Hae Wohn Johng, M.D.
Medical Director
Massillon State Hospital
Box 540
Massillon, Ohio 44648

WANTED! Top notch emergency physician to join established partnership staffing two Emergency Departments and three Urgent Care Centers in the Cleveland area. Must be residency trained, board eligible or board certified. Send CV to H. White, M.D., 1438 SOM Center Road, Cleveland, Ohio 44124.

Practice for Sale

PEDIATRIC PRACTICE FOR SALE: A Pediatrician is retiring from private practice. Has large and well-established practice located in southeastern suburb of Cleveland. Reasonably priced and seller will finance. Reply to Ralph P. Higgins, Attorney, 21010 Center Ridge Road, Rocky River, Ohio 44116.

Real Estate

FOR SALE: All brick building containing two offices. One 1200 sq. feet, and the other one about 1000 sq. ft. Located in the center of Kent, in North East Ohio. Call area code 216-673-5917.

SANIBELL ISLAND, FLA. LIGHTHOUSE POINT CONDOMINIUM, completely furnished, for sale by owner. Never rented, pristine condition. 3 B.R. magnificent bay view. Beach. $198,500. Assume 9% mortgage. 813-472-3719 or 317-251-0321.

Seminars

CHILDREN and DEATH: PERSPECTIVES AND CHALLENGES: November 9-11 at the Quaker Square Hilton, Akron. Sponsored by Children's Hospital Medical Center of Akron. Fee: $175 before October 26, $195 after. Education credit available. For more information: Vicki McDowell (216) 379-8238.

SYMPOSIUM

Renal Origin of Hypertension: Progress Over 50 Years

A symposium commemorating the production of experimental hypertension by Harry Goldblatt in 1934 will be held October 8-9, 1984 at Medical College of Ohio in Toledo, Ohio. Sponsors: Department of Pathology (MCO); CWRU School of Medicine; Council for High Blood Pressure Research, AHA, Program Chair; Peter J. Goldblatt, M.D., Chair, Pathology (MCO). Information/brochure, contact: Office of CME, Medical College of Ohio, C.S. 10008, Toledo, Ohio, 43699. Telephone: (419) 381-4237.

Rates: $5 per line. Display classified: $7 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $7 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 1st day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, *The Journal*.

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Doctor, you can't beat the quality or the price! HOLTER MONITOR SCANNING SERVICE, Physician owned, trained and supervised. Now using UP Service for faster turnaround time. No contracts to sign. We can arrange for lease/purchase of Holter equipment. Why are you paying more and getting less? DCG Interpretation (313) 879-8860.

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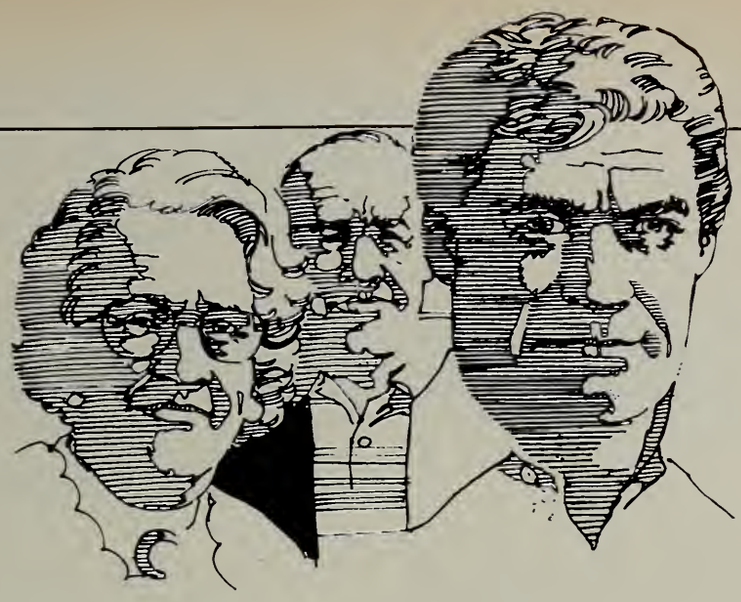
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Mail to: OMERF, The Ohio State Medical Association, 600 S. High St., Columbus, Ohio 43215

Colleagues In The News

ALAN ALEXANDER, MD, Beachwood, has been elected president-elect of the Northern Ohio Pediatric Society. He will serve a one-year term and will become president of the 340-member group in 1985.

EDWARD BOPE, MD, Columbus, has been elected to the Central Ohio Academy of Family Physicians' Board of Directors.

ROBERT CASTELE, MD, Medina, has been elected to the board of trustees of the American Lung Association of Northern Ohio.

MELLAR DAVIS, MD, Columbus, has been elected to the Medical Advisory Board for the Columbus Chapter of the American Red Cross.

SAUL GENUTH, MD, Cleveland, has been appointed to the American Diabetes Association's advisory board.

THOMAS HELMRATH, MD, Worthington, was recently honored by the American College of Physician Executives for having attained the highest level of achievement in both the practice of medicine and the management of health care organizations.

EVELYN HESS, MD, Cincinnati, recently received the Arthritis Foundation's National Award for Distinguished Service. The award recognizes Dr. Hess' leadership at the chapter level.

ARTHUR JAMES, MD, Columbus, has been named medical director of the Ohio State University Cancer Research Institute. Dr. James, professor emeritus of surgery at OSU, will oversee recruitment of the medical staff and programs for the 160-bed center.

RONALD KENDRICK, MD, Worthington, has been elected to serve as a member at large of the Ohio Orthopedic Society's Executive Committee. Dr. Kendrick has also been appointed chairman of the Health Planning and Evaluation Committee for the Academy of Medicine of Columbus and Franklin County.

WILLIAM S. KISER, MD, Cleveland, has been elected president of the American College of Physician Executives. Dr. Kiser, chairman of the board of governors at the Cleveland Clinic Foundation, will head the national organization of physicians who specialize in medical management.

GRANT A. LEIBY, JR., MD, Cleveland, has been elected to a three-year term on the Board of Directors of the Academy of Medicine of Cleveland.

RICHARD D. LONGSHORE, MD, Cincinnati, has been elected vice chairperson of the Home Health Personnel Advisory Committee (PAC). The committee establishes and reviews Home Health and Oriented Personnel Services, medical supervision, emergency care, nursing, therapeutic and social services.

ROBERT E. McARTOR, MD, Canton, has been appointed chairman of the Council of Family Medicine of the Northeastern Ohio Universities College of Medicine.

BRUCE MacMILLAN, MD, Cincinnati, was recently honored for his 20 years of service at the Shriner's Burns Institute in Cincinnati. Dr. MacMillan has been with the center since it opened.

RICHARD G. ORLANDO, MD, Columbus, has received the Roger T. Beitler medal from Kent State University. The award is presented to former Kent State students who have made exceptional contributions to society in their profession.

WARNER A. PECK, JR., MD, Cincinnati, has been awarded the Providence Hospital's distinguished physician award. Dr. Peck was the hospital's director of radiology from 1971 through 1977.

DOUGLAS A. RUND, MD, Columbus, has been named one of the co-directors of the Emergency Medical Services of the Columbus Division of Fire. Dr. Rund will be in charge of primary care training and continuing education for the services.

MERVYN D. SOPHER, MD, Cleveland, has been appointed director of the Division of Medicine at the Suburban Community Hospital in Cleveland.

WALTER STONE, MD, Cincinnati, has been appointed senior editor of the Monograph Series of the American Group Psychotherapy Association. Dr. Stone is also a member of the editorial board of the *International Journal of Group Psychotherapy*.

WULF H. UTIAN, MD, Cleveland, has been elected vice-president of the International College of Surgeons United States Section, and chairman of the group's Division of Obstetrics and Gynecology, United States Section.

THOMAS WERNER, MD, Cincinnati, has been installed as the 128th president of the Academy of Medicine of Cincinnati. Other elected officers include LEE VESPER, MD, president-elect; WILLIAM GATES, MD, past president; ANN GHORY, MD, secretary; and JOE HACKWORTH, MD, treasurer.

Simple to take.

In acute exacerbations of chronic bronchitis

- Clears susceptible pathogens from sputum[1-4]
- Reduces cough and sputum volume[1-4]
- Reduces evidence of inflammation[1]

Bactericidal *in vitro* against *H. influenzae* (nontypable strains)

Bactrim shows high activity *in vitro* against most strains of *H. influenzae*—even ampicillin-resistant strains. However, *in vitro* data do not necessarily correlate with clinical results.

In morphologic studies,[5] cultures of *H. influenzae* were exposed to Bactrim at 5× MIC. After just four hours, bacteria began to form filaments, indicating an alteration in the normal pattern of cell division. After 12 hours, virtually all bacteria had formed filaments. When these bacteria were removed and recultured in drug-free nutrient medium, almost all were unable to divide and form colonies—a result interpreted as demonstrating that, at the above concentration, the effect of Bactrim on the *H. influenzae* was bactericidal.

Also effective against susceptible strains of *S. pneumoniae in vitro*

In sputum cultures of *S. pneumoniae,* 91% of strains were susceptible to Bactrim.[6]

In acute exacerbations of chronic bronchitis involving *S. pneumoniae* or *H. influenzae,* sputum cultures taken seven days after a two-week course of therapy showed that Bactrim eradicated these bacteria in 91% (50 of 55) of the patients treated.[5]

Effective—and economical—antimicrobial therapy

In three double-blind studies, Bactrim DS *b.i.d.* was unsurpassed by ampicillin *q.i.d.*[1-3]

And in ten clinical comparisons with tetracycline involving nearly 700 patients, Bactrim proved comparable on major clinical parameters: change in sputum purulence, reduction in sputum volume and microbiological clearance of pathogens.[4]

And equally important: the convenient and economical *b.i.d.* dosage of Bactrim DS is designed to encourage patient compliance.

Bactrim™ DS

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Consistent success on a *b.i.d.* schedule

Please see references and summary of product information on following page.

References: 1. Chodosh S: Treatment of acute exacerbations of chronic bronchitis: results of a double-blind crossover clinical trial, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts.* Princeton Junction, NJ, Communications Media for Education Inc., 1980, pp. 15-16. 2. Chervinsky P: Double-blind clinical comparisons between trimethoprim-sulfamethoxazole (Bactrim™) and ampicillin in the treatment of bronchitis exacerbations, *Ibid.*, pp. 17-18. 3. Dulfano MJ: Trimethoprim-sulfamethoxazole vs. ampicillin in the treatment of exacerbations of chronic bronchitis, *Ibid.*, pp. 19-20. 4. Medici TC: Trimethoprim-sulfamethoxazole (Bactrim™) in treating acute exacerbations of chronic bronchitis: summary of European clinical experience, *Ibid.*, pp. 13-14. 5. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 6. The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter 1983.

BACTRIM™ (trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: **BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS.** Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1983 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

ISSN 0030-1124

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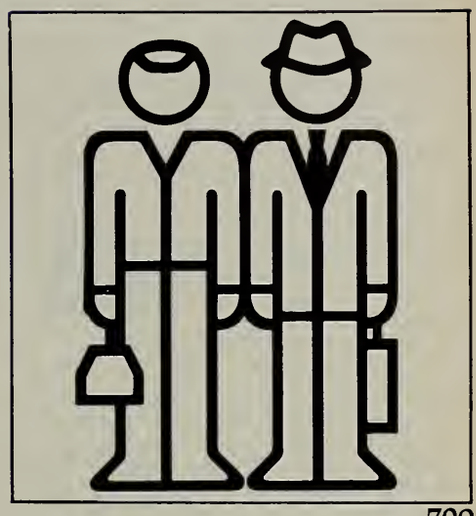
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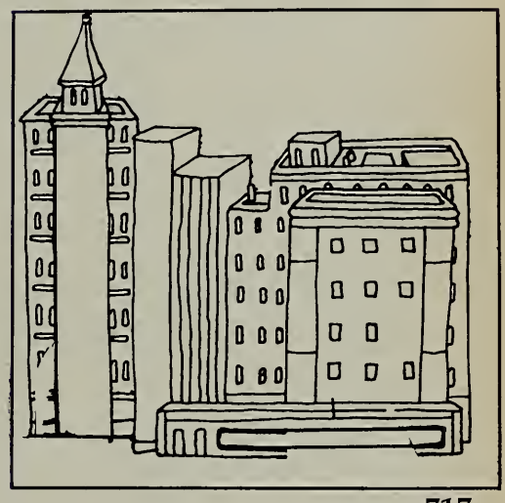
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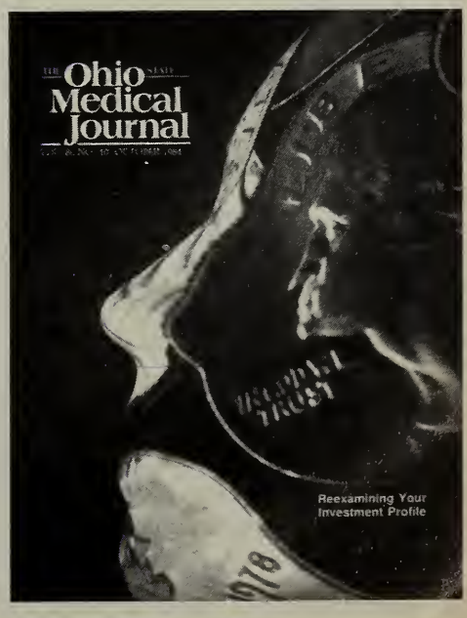
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So, we asked our authors to give us an updated look at their particular markets — stocks and bonds, real estate and gold.

And for those who are *still* nervous about investing, we've even included an article about how to choose a financial consultant — so you don't have to wander into the marketplace alone.

Even if you aren't interested in investing — or you already have the marketplace figured out and have taken care of securing your earnings — you'll still be interested in reading about the current worth of your practice. It may be more valuable than you thought!

Please keep in mind that we are not trying to advise you or tell you where to put your money. It's your money, and only you can decide what to do with it. But by providing you with as much information as we can — from some of Ohio's leading experts in investment fields — we hope to keep you, our reader, educated and up-to-date on today's financial climate.

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Letters to the Editor

To the Editor:

I read your very interesting article in the August *Ohio State Medical Journal* regarding Dresden and its family doctor. I believe this is a positive sign for family practice and found it very interesting to read about Dr. Bulen and his burgeoning practice in Dresden.

I would like to bring to your attention another family doctor in our area, Dr. Bill Fiorini, who recently began practicing in Somerset, Ohio, another small community. His acceptance in Somerset has certainly been overwhelming from my vantage point.

I believe that more articles regarding these physicians who do locate in small towns would be well received and prove to be interesting reading for all the members of OSMA.

Sincerely,
John G. O'Handley, MD
Lancaster, Ohio

Correction

In the August issue, author A. Robert Davies, MD, was identified as a family practitioner. In fact, Dr. Davies is an internist, and a member of the Board of Trustees of the Ohio Society of Internal Medicine.

WANT TO EXPRESS AN OPINION?

The OSMA Journal *welcomes letters from its readers. Please address all letters to: Executive Editor, 600 S. High St., Columbus, Ohio 43215. Letters may be edited to meet space requirements*

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The Government As a Health Insurance Agent

By David S. Starr, MD

It is almost a truism that whenever a government enters an area inappropriate to its central activities, it falls flat on its face. In the case of America, and fortunately for the politicians, they have the apparently unlimited resources of the American taxpayer to back up their observable poor judgment. Of course, one should consider that the principal motivation for intervening in the first place is the desire to be seen "doing something," and that the mere act of intervention, although a total failure on objective data, can be a political success because of this. It is not, therefore, surprising that politicians are constantly tempted to intervene in inappropriate areas, and commonly succumb to that temptation.

Indeed, the American people have displayed a fundamental strength of common sense in taking as little notice of their federal government as they possibly can. However, the monster has grown to such gargantuan proportions that it can no longer be ignored. The skeleton in the closet has become a dinosaur in the basement.

One must wonder, whether the federal government, at present poised for a massive intervention into medical care in the USA, has any doubts as to its ability to successfully deal with the difficult problems which it presents.

I believe that the massive increases in federal health care costs over the last 10 years have directly resulted from a confusion between the public and the private interest in the mind of government bureaucrats. There are many historical examples to show that the maintenance of public health programs is a tremendously cost-effective way of spending public money. At the other extreme, an open-ended guarantee of individual health care by the government or any other body cannot, by its very essence of that promise, be economically viable in the long term.

I believe the massive increases in federal health care costs have resulted from a confusion between the public and private interest in the mind of government bureaucrats.

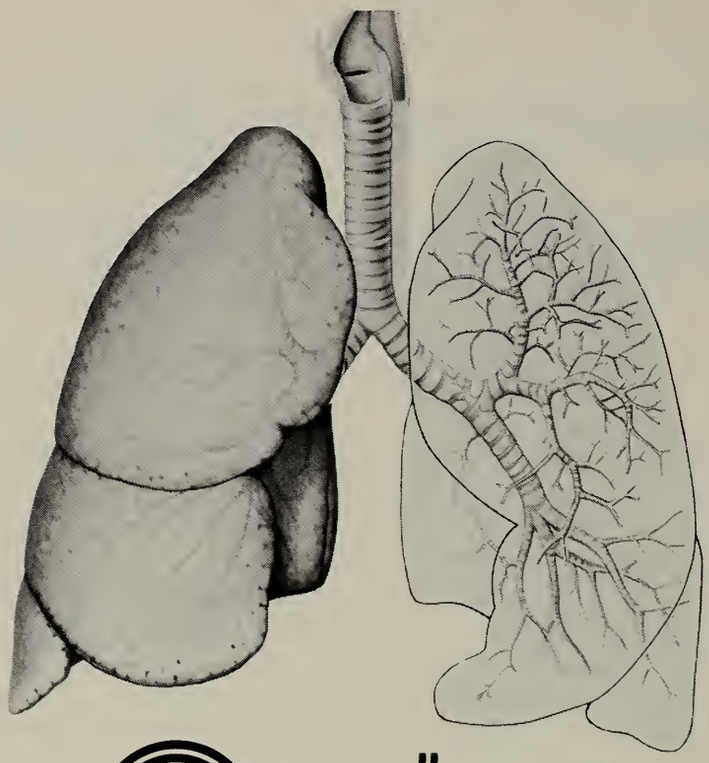
Basically, I believe that the government should not act as a primary health insurer. I believe it should act to maintain genuine competition between private or corporate-based health care schemes, and to prevent price fixing, monopolies, and the like i.e., distortion of the free market.

However, the incipient failure of previous government insurance schemes (e.g. social security) should act as a cautionary note to fools who are only too ready to rush in where angels fear to tread. The very best in modern medicine is exorbitantly expensive. As opposed to public health programs where a few dollars produce tremendous overall benefit, an open-ended promise that "everything will be done" is simply not an economic proposition. I do not believe it is appropriate for the State to guarantee each individual unlimited health care without regard for cost.

If the government does choose to intervene on a massive scale, and thereby tacitly guarantees unlimited health care to every citizen, it must soon discover how expensive this can be. Even a massive and punitive taxation scheme, plundering a surprisingly complacent and uncomplaining tax payer, would be insufficient to fund such an open-ended commitment. In this situation, even the US government must take the road that many other governments have taken before it. In the end, by one means or another, either directly or indirectly, the government must limit access to health care resources.

It can do this by using waiting lists, by restricting numbers of beds in certain areas, by limiting dollar allocations to hospitals, by requiring certificates of need for every new piece of equipment, or just by tying every expensive article or service up in a web of bureaucratic entanglement.

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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor® (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosterords appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[0617B2R]

Note: Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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The Government as Agent

continued

Some or all of these features are found in every government health care system.

The question must arise in one's mind: do the politicians know already that their grandiose schemes are destined for failure, or do they not even have this insight? One suspects that their primary purpose is not to produce a workable scheme, but to be seen "doing something," and that after the glow has faded and the problems are seen in closer focus, they will have moved on to greater things, possibly a job in private industry, advising the government how to get out of that mess, or perhaps a multi-million dollar government pension (with free medical care, of course).

I suspect that politicians have made a basic error in confusing the fundamental rights on which democracy is based — the right of free speech, the right of assembly, etc. — with the "right to health," which I believe is a socialist fantasy, useful perhaps for collecting politician's extra votes, but not attainable in the present world. And perhaps there are some who agree with me. **OSMA**

David S. Starr, MD, practices cardiovascular and thoracic surgery in Youngstown, Ohio.

Rebecca J. Doll Joins Market Group One, Inc.



Market Group One, Inc., the Columbus-based firm which specializes in meeting the marketing needs of physicians and their organizations, is pleased to announce the addition of Rebecca J. Doll as a new partner and Vice-President.

Ms. Doll has been Associate Executive Director of the Ohio State Medical Association, and Director of its Department of Communications for ten years. Her innovative marketing and communication's programs for OSMA have received national acclaim not only from medical professionals but from those in the marketing and communications industries as well.

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Next month in:

THE Ohio STATE Medical Journal

The Physician Image

How is it Changing?

Like it or not, doctor, you have an image . . . one that seems to change almost constantly as the public's perception of the medical profession wavers in and out of favor.

Next month, the *Journal* will take a look at that image — how it is changing and why.

We will be examining, for example, how the entertainment industry is currently depicting the role of physician in films and on television, and how and why real-life physicians appear in the news media.

If you haven't checked your image lately, doctor, next month will be your chance to do so. You may just be surprised at what you'll see.

NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by Susan Porter

Herbert Gillen is Executive Director Designate

Herbert Eugene Gillen was named Executive Director Designate of the Ohio State Medical Association (OSMA), following the September 15 meeting of the OSMA Council. Gillen, age 50, will take the place of Hart Page, who is retiring from the head OSMA position next May, but who will remain as a consultant through the end of next year.

Gillen, a native of southern Illinois, earned his Bachelor of Science Degree in Health Education from Southern Illinois University in 1956 and his Master's in Public Health from the University of Michigan in 1961. He then came to Ohio as a public health educator for the Ohio Department of Health.

In 1963, Gillen was employed by the Ohio State Medical Association as an administrative assistant. He has served as Director of the Department of Government Relations for the past 15 years and as Deputy Executive Director for the past two years.

Gillen, his wife Betsy, and their three teenage children, Herb, Shelli and Christi, reside in Upper Arlington, Ohio.



Herbert E. Gillen

Interest in home-births, nurse-midwife deliveries are increasing

The number of babies delivered by nurse midwives more than doubled between 1975 and 1979, according to a new report from the National Center for Health Statistics titled *Midwife and Out of Hospital Deliveries United States, 1978-79.* Since the number of out-of-hospital deliveries remained relatively constant, the figures reveal the increasing interest in home births and in hospital births attended by midwives, the publication says.

Information for the study was obtained from entries on live birth certificates filed in the US in 1978 and 1979. Data was compiled both on nurse midwives, registered nurses who have obtained additional education in delivery and the lay or "granny" midwife who typically serves low economic or rural areas.

The report indicates that three types of women deliver in nonhospital settings: those who cannot afford a hospital confinement, those who desire a more natural family-centered birth experience, and those who intended to give birth in the hospital but go into labor and deliver accidentally at home.

New Director named for OSMA's Communications Department

Carol Wright Mullinax has been named the new Director of the Ohio State Medical Association's Department of Communications, replacing Rebecca J. Doll who resigned from the position October 1. Doll, who had been with OSMA for 10 years, joined Market Group One, a Columbus-based health marketing firm, as a Vice-President and partner.

Mullinax, who served as associate director of communications prior to the appointment, is a native of Wadesboro, North Carolina.

A 1978 graduate of the Ohio State University where she earned her BA in Journalism, Mullinax came to the OSMA in that year as the editor of *Synergy*, the association's monthly health education tabloid. In 1979 she was named assistant director of the Department of Communications and in 1981 she was promoted to associate director of the department.

Prior to joining OSMA, Mullinax was employed by the Ohio State Bar Association.

According to Mullinax, a top priority for the coming year will be to help educate the public about medical issues, as well as to improve the image of physicians.

In order to achieve this, she says, her department will be concentrating on media relations in an attempt to improve physicians' access to the media, and will continue to look at marketing as another alternative.



Health care needs changing

As the nation grows older, the health care needs of Americans will change dramatically, a professor of internal medicine and the head of the geriatrics division at the University of Virginia School of Medicine told a group of life insurance medical directors recently.

Pointing out that many elderly patients need rehabilitative care rather than high technology care, Richard W. Lindsay, MD, predicted that "rehabilitative centers," which assist elderly patients with simple tasks like dressing, bathing and climbing stairs, will become an essential component of the nation's health care system in the future.

Currently, "50% to 60% of nursing home patients do not receive rehabilitation," he said, and subsequently they progressively decline in their abilities to function. "We must add to the rehabilitative facilities in this country," Dr. Lindsay urged in his address at the ninth annual meeting of the Medical Section of the American Council of Life Insurance.

He also recognized the importance of hospice care which takes care of "all the needs of the terminal patient." He noted that while there were only 80 hospices in the U.S. in 1980, there are now 1,500 to 2,000 across the country.

Doctors say hospital costs too high

Most doctors think hospital costs are too high and favor changes in the health care system which would reduce hospital stays, the results of a recent nationwide survey of 500 physicians indicate.

However, the study conducted by Louis Harris and Associates for the Equitable Life Assurance Society, also shows that most physicians are opposed to Diagnosis Related Groups (DRGs) and other price-fixing methods, along with government price controls intended to keep costs down.

According to survey highlights published by Equitable, physicians think that seven different factors have contributed significantly to the rise in health care spending over the last few years.

They are: the increased use of expensive equipment and technology; the aging population; malpractice suits and insurance; government-funded health care programs such as Medicare and Medicaid; employer-provided health insurance; unnecessary laboratory tests and unnecessary hospitalizations.

Suggestions for controlling costs which gained the approval of the majority of physicians surveyed included:

- increasing deductibles and copayments on insurance policies to promote cost-sharing by patients;
- discouraging the duplication of expensive equipment and specialists at nearby hospitals;
- developing insurance plans that provide individual incentives for healthy living or group incentives far below target expenditures;
- changing laws relating to malpractice and thus reducing the pressure to practice defensive medicine;
- changing anti-trust laws so that third-party payers can join together to negotiate fees with providers; and
- forming business coalitions to control health care costs.

Among other proposals suggested in the survey, which the majority of physicians felt were unacceptable were: development of HMOs and other preferred provider plans; using nurse practitioners, midwives, and physicians' assistants in place of physicians; and cost-shifting techniques to relieve Medicare and Medicaid and place more of the burden on the private sector patients.

Radiotherapy is treatment choice in Kaposi's sarcoma

Radiotherapy should be considered the treatment of choice in selected cases of Kaposi's Sarcoma in conjunction with acquired immune deficiency syndrome (AIDS), say Jay S. Cooper, MD, and colleagues from NYU Medical Center in New York. They report on 15 patients so treated. All tumors exhibited at least partial regression, and the majority responded completely," the researchers say. Chemotherapy typically is used for such patients, but the researchers maintain radiotherapy is preferable. *—Journal of the American Medical Association*

continued

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Physicians' income levels, job satisfaction to decline

The personal satisfaction physicians gain from their medical practices, along with their income levels, will decline over the next 10 years, predicts a study conducted recently by the American College of Hospital Administrators and Arthur Anderson & Co., an international accounting and consulting organization.

The survey of 1,000 health care leaders indicates that competition among doctors will be strong over the next decade, as patients rely more heavily on self-diagnosis and treatment, and as consumers become better educated and more cost conscious about health care.

It also predicts that even though health care's share of the Gross National Product will continue to grow, that portion received by the



hospitals will decrease, as patients have a wider choice of professional health-care sources, such as diagnostic centers, freestanding emergency centers and surgery centers. As a result, more hospitals will become affiliated with hospital chains in order to survive.

Second opinions will become more the rule than the exception, the survey further indicates. However, by 1990, Congress will pass legislation to limit the amount patients can win for malpractice awards, the survey participants predict.

Among Ohio participants in the eight-month study which included some 1,000 physicians, hospital and nursing home administrators, health insurers, legislators and suppliers of health care goods and services were: Thomas Pritchard, assistant vice president for finance at Blue Cross of Central Ohio; Michael Tootell, administrator of health programs for the Ohio Board of Regents; Joseph Sanderell, chief of the bureau of medical services of the Ohio Department of Health; and Stanley Sells, chief of the state Medicaid program.

Drug Capsules

New mainstays for osteoporosis

Estrogen and calcium are the mainstays of preventing and managing osteoporosis, the age-related disorder characterized by decreased bone mass and increased susceptibility to bone fracture, says a recent concensus conference report published by the National Institutes of Health.

Women who begin estrogen replacement within a few years after menopause have far fewer hip and wrist fractures than women who do not begin therapy, and even those who start as late as six years after menopause are spared further loss of bone mass, even though it is not restored to pre-menopausal levels.

It is also believed that an increase in calcium intake to 1,000 to 1,500 mg per day, beginning well before menopause, will reduce the incidence of osteoporosis, the report says. Most people, however, do not even take the daily recommended intake of calcium of 800 mg, but typically take only between 450 mg and 500 mg.

Exercise and nutrition are also important adjuncts to treating osteoporosis, which affects some 15 million to 20 million people in the United States and causes some 1.3 million fractures each year.

Acne drug may cause birth defects

Isotretinoin, (Accutane) a drug used for severe acne, can cause birth defects in infants, warns a recent article in the *Journal of the American Medical Association (JAMA).*

Researchers report that the mothers of two infants born with a series of anomalies, including hydrocephalus, malformed ears, small mouth and cleft palate, had both taken the drug in the first trimester of pregnancy. Neither child survived.

"Accumulating experience suggests that isotretinoin is one of the most severe teratogens (agents causing defects in the developing fetus) seen to date in man," one researcher states, adding that even modest use of the drug can lead to severe defects.

Isotretinoin is a retinoic acid that inhibits the production of sebaceous gland lipid and is commonly used in severe nodular and cystic acne. It has been marketed in the U.S. since 1982.

Antibiotic approved

The first of the new long-acting antibiotics recently approved by the Food and Drug Administration promises to save hospitals time, materials and labor. This second generation cephalosporin cefonicid (Monocid, Smith Kline and French Laboratories) was approved last month for use in urinary and lower respiratory tract infections, skin, bone and joint infections, septicemia and surgical prophylaxis.

Researchers report that use of a long-term antibiotic could cut back on the number of doses of drug per day as well as the number of days of antibiotic use. By reducing the number of doses each day, hospitals could save roughly $5.40 per patient each day; the overall reduction in antibiotic use could save an average of $155 per bed per year.

Additionally, patients could be treated outside the hospital rather than remaining as inpatients.

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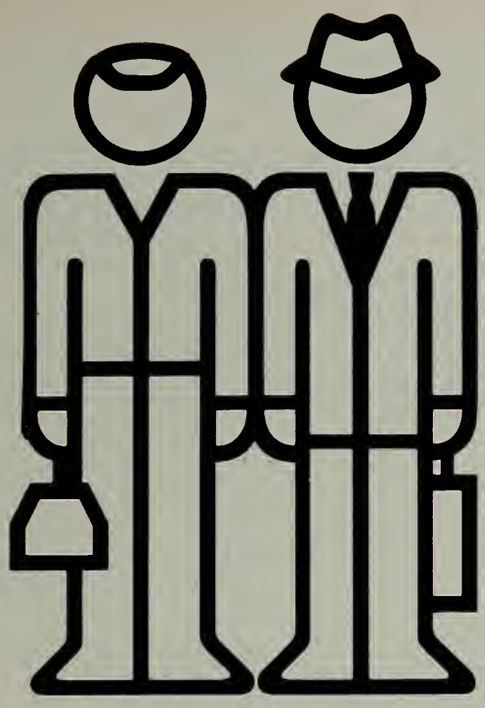
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Dayton's "Movers and Shakers" Get an Inside Look at Medicine

By Susan Porter

One year ago this November, William J. Marshall, MD — then President of the Montgomery County Medical Society, now OSMA Second District Councilor — went to his board with an unusual request. The November elections were over, and the newly-elected and incumbent public officials were already snug in their seats for another term. The hotbed of political coverage that fills the media before voting day had also died down.

But, as with each new election, Dr. Marshall knew that the real issues — the day-to-day decisions each of these politicians, judges, journalists and legislators would make — had only begun. And a greater and greater portion of these issues, he realized, revolved around health care and the way it is delivered.

"It was obvious to a lot of us that the 'shakers and movers' who have a lot to say about health care policy have had only one real experience with medicine — and that is the one with their own personal physician," he says. Therefore, he began looking for some way to enable those community leaders to broaden their horizons — to widen their understanding of what medicine is and how it works.

"It was obvious to a lot of us that the 'shakers and movers' who have a lot to say about health care policy have had only one real experience with medicine — the one with their own physician."

He found just such a way in an article which appeared in the October 23, 1983 issue of the *New England Journal of Medicine*. The article described a "mini-internship program" being piloted in Portland, Oregon, which allowed local legislators, public officials, administrators, business executives, judges, reporters and other lay leaders in the community the chance to spend two days in a white coat at the side of a working physician.

"The program sounded exactly like what the doctor ordered," Dr. Marshall recalls.

He therefore suggested at the Montgomery County Medical Society's November meeting that Dayton undertake such a program. He was overwhelmed by the response. "I was really surprised — everyone was enthusiastic."

As outgoing president, Dr. Marshall was asked by incoming President Harold G. Kelso, Jr., MD, to chair the program. He readily agreed, and over the next month spent many hours developing support for the program within the membership. The hard work of he and his newly appointed committee paid off.

"We now have 50 physicians in all areas who have volunteered to serve as faculty for the program," he says. "We have men and women in every specialty, from emergency medicine to psychiatry."

Faculty were hand-picked by the committee not only for their reputations as quality practitioners but also for their "proven abilities as teachers," Dr. Marshall says. However, they are all "middle-of-the-road" kinds of individuals who have a wide range of interests, he adds.

Likewise, interns were chosen not only for the impact they might have on the health care system, but also for the reputations they hold within the community. Among those singled out for the program were the presidents of local companies, politicians, journalists, lawyers, judges and various representatives from the service industry, Dr. Marshall says.

The society is in hopes of getting its first program off the ground by the middle of this month. Eventually it plans to have 10 interns going through each program, three to four times a year. However, only five interns will be involved in the initial October start-up.

"We need a trial run," Dr. Marshall explains, "a chance to work out problems on a small scale as they arise."

Recently, personal invitations were sent out to the president of a large company, a newspaper person, a judge, a benefits manager from a large corporation and a county politician, asking them — and them alone (no substitutes allowed) — to participate. While the committee feels certain most, if not all, will accept the invitation, Dr. Marshall does point out, "The commitment is a substantial one. The program runs over several days, and it's an all-or-nothing proposition. You can't just participate in part of it."

Like the program in Oregon, Montgomery County's mini-internship program will begin in the evening with a preliminary dinner, enabling the interns to meet faculty members and to ask questions about what they'll be doing. They also will be issued the white smocks and name tags they will wear the duration of the program.

Bright and early the following morning, each intern will be assigned to spend the day with a primary care physician. Like the doctor, the intern will be on call, 24-hours-a-day.

The second 24-hour period will be split between two physicians in specialties highly involved in hospital work. "This will give them some experience with a family doctor and those physicians who are more proceduralists — who depend more on hospital back-up," Dr. Marshall explains.

The next day, faculty members will meet for a luncheon debriefing, while interns will hold an evening meeting with the committee to share their concerns and comments. "We are hoping to get a good solid critique of the program," Dr. Marshall says. "In this way, we'll be able to improve the tempo of the program as we get into it."

Even after this first trial run — when the mini-internship program has become an ongoing, established program in Montgomery County — the debriefings will continue to be a key part of the program, says Dr. Marshall. It is through this exchange of experiences and viewpoints that the society hopes to accomplish its goal — to build a rapport, a common area of understanding, between physicians and community leaders. As a result, Dayton physicians are hoping the experience will have a positive impact on the day-to-day decisions these community leaders make long after the November elections are history.

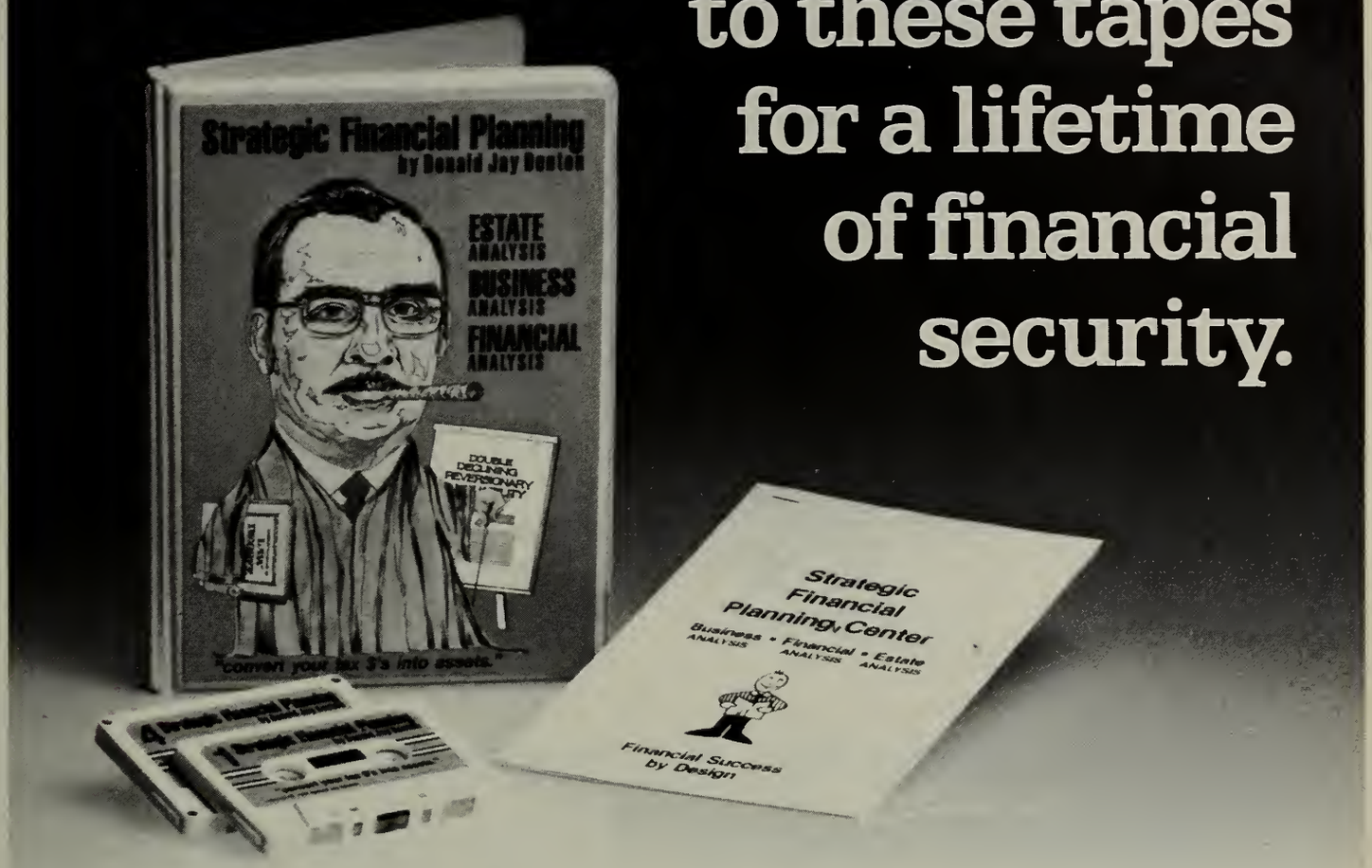
"The only long-term benefit we hope to gain is to give these people who are making some very important decisions for both us and our patients an inside look at the art of medicine, as well as the science," says Dr. Marshall. "We want to enable them to observe the one-to-one relationship that goes on between the doctor and the patient, so that they can get a better understanding of all the ramifications that go into the everyday decisions *we* make." **OSMA**



"The commitment is a substantial one. The program runs over several days and it's an all-or-nothing proposition. You can't just participate in part of it."
William Marshall, MD

Susan Porter is Assistant Editor of the **Ohio State Medical Journal.**

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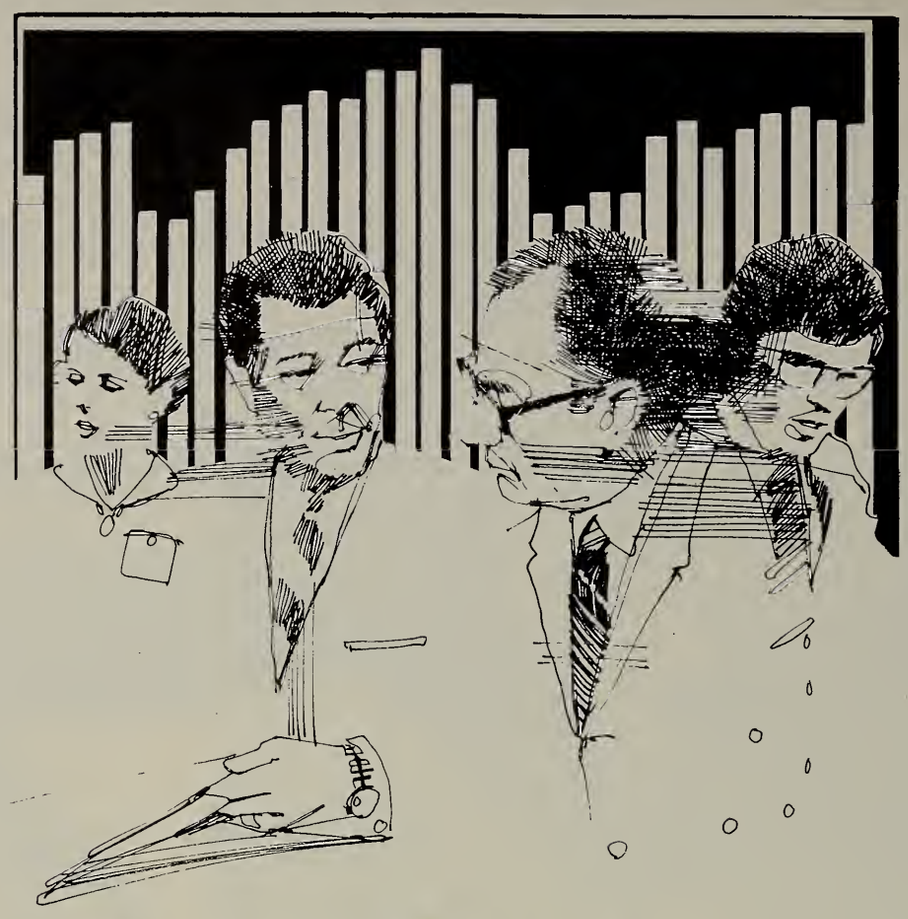


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Strong Economy Means Sound Investments

By William A. Clark

The last half of 1982 and all of 1983 were some of the most productive times in many years, for both stocks and bonds. The average growth in most common stock portfolios for 1983 ranged from 20% to 30%. Bond yields reached the highest level in years. Physicians who began an investment program during these times picked a most opportune time.

The first half of 1984, however, has witnessed a significant drop in the market. This has been due to profit-taking, political and economic uncertainties, and consolidation after an unprecedented advance in the market over an 18-month period.

The questions in everyone's mind today is, where will we go from here? Are there still opportunities for good, sound investing and will the market be strong for the next year or two? We believe there are still many outstanding opportunities for investing now.

The question in everyone's mind today is, where will we go from here? Are there still opportunities for good, sound investing? We believe there are...

First, let's review the background scenario for making such an optimistic statement. The economy is in the strongest position we have seen in many years. Inflation is now 4% and is expected to remain at a low 5% to 6% for at least the next two years.

Under these kind of conditions, the stock market should reach new highs. Investor psychology is now more positive. While each market advance will be tempered by periodic set-backs, new highs in the major averages should be seen soon.

Some of the industries expected to show above average growth potential are drugs, defense electronics, retailers, electronic equipment, pollution control, hospital management, selected medical supply and health care companies and restaurants. Some outstanding companies in each area are listed in the chart which follows.

Many other selected companies in other industries are expected to enjoy

Outstanding companies expected to show above average growth:

Drugs:
- Abbott
- Bristol Meyers
- American Home Products

Defense:
- Sanders Assoc.
- E-Systems
- Avco Corp

Electrical Equipment:
- Emerson Electric
- Thomas & Betts

Pollution Control:
- Browning & Ferris
- Waste Management

Medical:
- Humana
- Baxter Travenol
- Home Health Care
- Marquest Medical
- American Medical Int'l.
- Urgent Care Centers

Restaurants:
- Wendy's
- Rax
- Bob Evans Farms
- Cracker Barrell Country Stores

Retailers:
- Sears
- Federated Dept. Stores
- Limited
- Charming Shoppes

excellent opportunities for capital gains. Some selected utilities offer good total return prospects, such as Consolidated Edison, Potomac Electric and Minnesota Power.

Most physicians will have at least three or four different areas of investment planning:

1. Personal account
2. Pension or Profit Sharing Plan
3. Children's custodian accounts
4. I.R.A.

The personal investment plan should include non-taxable income investments such as growth stocks, tax-free municipal bonds, and perhaps some conservative tax shelters. Good quality municipal bonds are currently yielding 9½% to 10%. A recent popular type of municipal bond trust is the Insured Municipal Bond Trust. These trusts eliminate any chance of a default of any individual issue in the trust by providing a blanket insurance policy covering the entire group of bonds. These AAA rated tax free investments are excellent for any professional in a high tax bracket. They are currently yielding 9½% to 10%.

In the pension or profit-sharing account, the objectives are high income and good growth. Since all income and capital gains are sheltered from taxes until retirement, high yielding bonds provide an excellent base combined with growth stocks. AAA rated, GNMA pools of Government guaranteed mortgages provide high-yielding, fast pay back investments for this type of account.

Most physicians will have at least three or four different areas of investment planning: personal, pension, children's custodian and IRA.

Another form of AAA rated bonds are GNMA collateralized bonds. These are issued by a corporation, but are secured by an equal amount of GNMA mortgages as collateral. Both of these types of investments are currently yielding in the area of 12% to 12¾%.

Another recently popular type of bond for pension accounts, and also custodian accounts are Certificates of Accrual of U.S. Treasury Bonds. Given the name CATS, these top quality certificates accrue interest daily, but do not pay until maturity. Thus they are called "zero coupon" type bonds. They are bought at a deep discount, and give high yields due to the internal compounding of interest on interest.

These investment suggestions are but a few of the many opportunities available today. Every physician should be actively pursuing his or her own personal investment goals with a reputable advisor. The worst mistake that can be made is to "sit tight" and do nothing. There is always a good investment if we search for it. **OSMA**

William A. Clark is vice president of The Ohio Company in Columbus.

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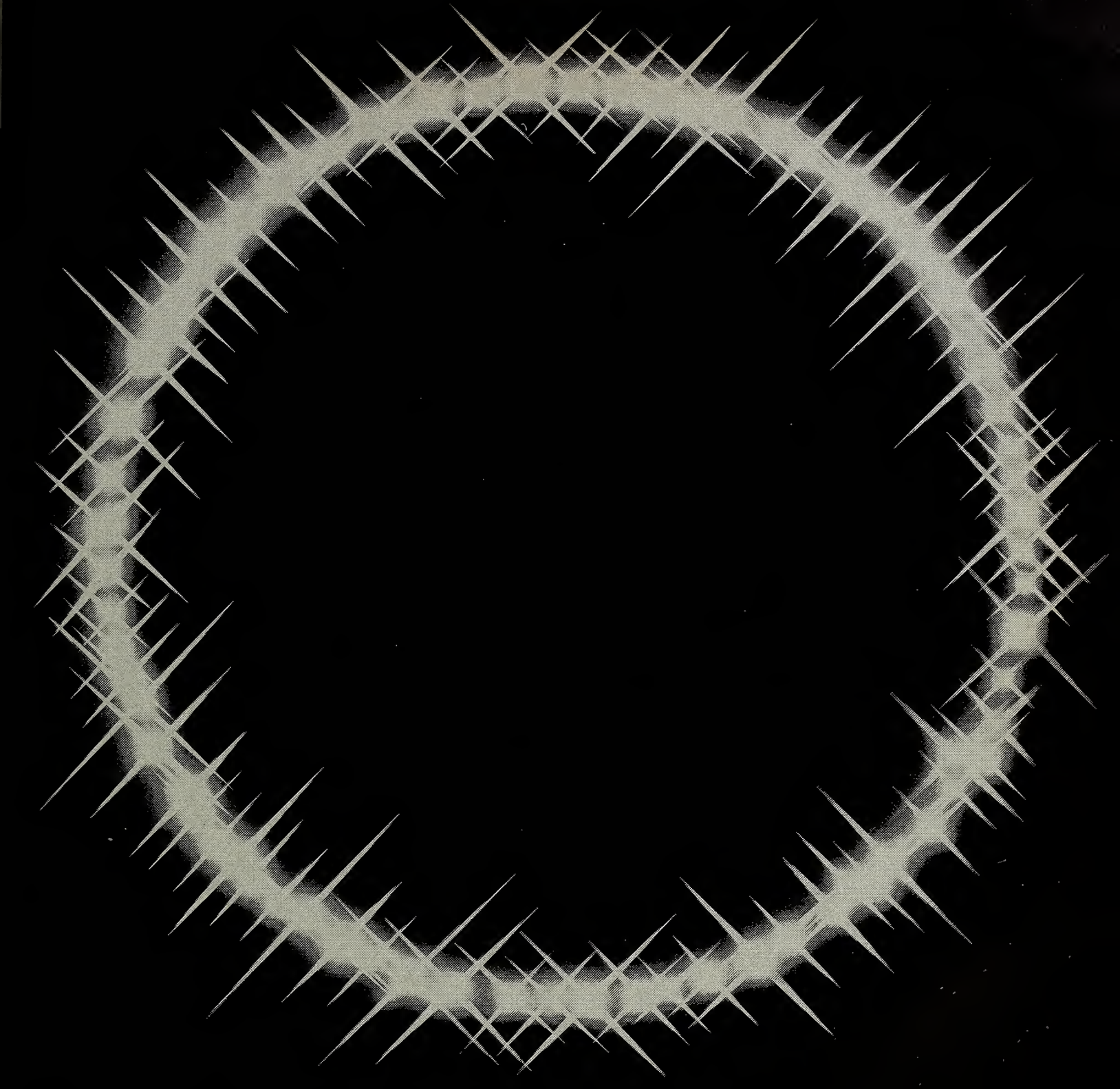
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Investing in Gold Loses its Sparkle

By Joan S. Fulton

"It's exciting. It's thrilling. But you have to know what your investment objectives are and you have to know with whom you are dealing."

Two years ago, those were the words of W. Arthur "Art" Cullman, Jr., vice president of investments for Prudential-Bache Securities in Columbus. He was discussing gold as an investment.

Now, two years later, Cullman's tone has changed considerably. Compared to the "gold rush" that occurred two years ago, investing in gold has lost much of its sparkle.

"Gold, as an investment, is very inactive, unexciting, hasn't been in the news and hasn't done anything spectacular," he says. "One of the big factors that affected the price of gold was President Reagan's curbing of inflation. It (inflation) has come to an

almost screeching halt, compared to the so-called 'double digit' inflation of the past. So buying gold as a hedge against inflation has pretty much disappeared."

Also, "The value of the dollar is the strongest it's been in years," Cullman says. "People won't buy gold as a hedge until fears of inflation occur again.

"Another factor affecting the price of gold is that fears about the safety of the world have lessened," he continues. "We still have trouble in the Middle East, but people have learned to live with it. The news is only scattered, and many days it isn't even top news. Escalation of war problems is very influential on gold prices, and right now it is not a factor."

So what happened to those people who invested in gold two years ago?

"If they held on to it, they neither made nor lost money," he says, "but they have had their money tied up in a non-productive investment. During that time period, we've had some high interest rates, which means they (investors) lost the opportunity to invest that money at 10% to 12%. Whenever you are figuring return, you have to consider another option you may have missed because your money was tied up in a nonproductive investment. However, I think that at some point, inflation will return and the price of gold will go up."

Even with government's efforts to keep inflation low, Cullman feels its rise is inevitable. "The forces that create inflation are those people all over the country who want more than they're getting. Those forces will always be there," he says.

The general state of the economy is closely linked with investments of all types, he adds. "The economy is coming back without inflation so far. How long we can do this will show us how well the stock market's going to do, how well our currency is going to do and what interest rates are going to do. All those things are contingent upon the balance of the economy, and they all intertwine. When any one of them gets out of control, it will twist or drag the other ones in whatever directions they go, based on what the scenario is. If interest rates go back up, the stock market is going to go down again, and the economy will start to back off. It's a vicious cycle."

Those hedging inflation or fearful of world conditions are not the only ones whose interest in gold as an investment has dropped. Coin dealers and scrap metal dealers have also lost interest.

"That business is down — way down," says Cullman. "You don't see any more of those TV ads saying 'Send your old rings to us and we'll send you cash.' There are no more scrap metal weekends when the public is urged to bring rings and sterling silver to a collection event at a motel. An awful lot of those instant businesses that cropped up have disappeared."

Those hedging inflation or fearful of world conditions are not the only ones whose interest in gold as an investment has dropped. Coin dealers and scrap metal dealers have also lost interest.

And as a result, "The amount of money spent in the print media, publicizing the buying of precious metals is also down," Cullman says. And "the number of companies doing this kind of business is way down. A lot of them, the fraudulent ones, got caught. When people who bought from those companies tried to cash in profits the money wasn't there. It became evident that there were fraudulent situations."

Many of these companies appeared to be reputable and advertised in reputable financial publications. So how does the ordinary person recognize this kind of fraud?

"The only way to avoid fraud is to know with whom you are dealing," he says. "If you get a call, particularly an out of state call, from somebody promising you a 'no risk, can't lose' deal that will make you bundles of money — watch out."

He recommends, instead dealing with local brokerage firms, banks and coin dealers with longstanding reputations that can be verified.

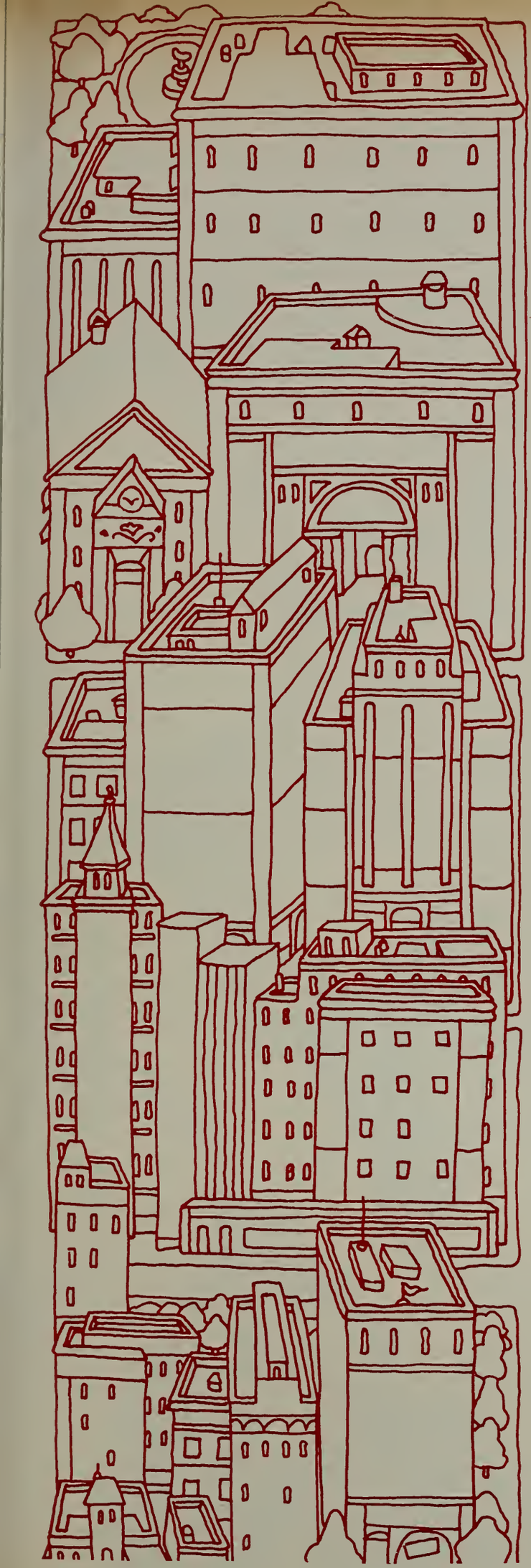
"Even out of state companies who may boast of being registered or licensed are not always what they appear to be," he warns. "The investor does not know what criteria were used to register or license that company. It doesn't always mean that a state has investigated the company and made it a legitimate corporation."

His advice, therefore, is direct and simple. "Don't buy from people you don't know. It has no advantage, and it has lots of disadvantages."

Cullman and other financial experts agree that if an investor is determined to buy out of state, he or she should at least check with the Better Business Bureau there. Companies who claim state registration or licensing may also be checked through the attorney general's office of that state.

In spite of the many changes in the financial marketplace, Cullman's advice to would-be gold investors is essentially the same as it was two years ago. "First define your objectives, then know with whom you are dealing — and bear in mind that burnished hopes can quickly turn to tarnished dreams. **OSMA**

Joan S. Fulton is a free-lance writer who currently writes for Suburban News Publications, Inc. in Columbus.



Real Estate Investments: They're Better Than Ever

By Richard L. Royer

In spite of today's constantly-shifting economic and regulatory environment, real estate still offers the investor one of the soundest options available, even during periods when the rate of appreciation on the investment has been slowed down.

During the past two years, some key aspects of our nation's economy have changed. Interest rates, which were at record high levels in 1982 have stabilized, although remaining at fairly high historic levels. The dollar has strengthened greatly in relation to foreign currencies. Inflation has been harnessed, and all indications are that it will remain under control for at least a short-term future. And, various pieces of legislation have been passed that affect the real estate investment climate.

However, the basics of real estate as an investment haven't changed — an investor still wants to do three things: assure that his or her money is safe, earn a return on it, and be sure that it grows.

There is no question that the current economic climate has created a few new wrinkles in the real estate investment picture. First of all, while the lower inflation rate of the past three years or so has been good for the economy in general, it has caused a slowdown in the appreciation of real

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estate values. Those who invested large sums of money in real estate with the hope of obtaining giant, inflation-fueled rates of return on their investment have been sorely disappointed. This strategy was successful for many investors in the 1970s, but that has changed. Now, an investor has to take a closer look at what his or her goals are and consider the longer-term results of a real estate investment.

Financing too, has changed. Financial institutions are no longer willing to commit funds for long terms as they have in the past. You may have to settle for a long-term amortization with a roll over provision of three or five years. Consider: will it be easy for you to raise the rent in the investment property you're considering to cover the cost of refinancing at a possibly higher rate when the loan rolls over?

Another factor to consider is the depreciation write-off advantage of investment properties. A recent tax bill passed by Congress lengthened the depreciation period from 15 to 18 years. At this point, it's too early to tell how much or if this change will dampen investment incentives; even with the longer write-off period, this type of investment still offers a significant tax advantage.

Congress also recently passed legislation mandating a dramatic increase in the interest rate required in seller-financed real estate transactions. For many years, owners have been able to finance the sale of their property by "taking back the paper" or loaning part of the purchase price to the buyer of the property at terms much more affordable than those available from conventional lending sources. This has been especially valuable during high interest rate periods.

The new law passed by Congress requires that beginning January 1, 1985, sellers charge buyers interest equal to at least 110% of the interest paid by the federal government on obligations of similar maturity. For example, if a seller takes back financing for 10 years, he or she must charge the buyer 110% of the rate which the federal government pays on 10 year notes. Federal 10 year notes are today about 13%, meaning that a seller must charge at least 14.3%. The current seller-financed rate is about 11%. Sales of principal residences costing under $250,000 and farm sales under $1 million are exempt from this provision.



If you're thinking about investing in real estate for the first time and you're reluctant to go it alone, consider the option of syndication. Syndication pools the resources of a number of limited partner investors to buy large-scale projects such as office buildings and shopping centers. The risk you take is limited to the amount you've invested, and you still get the tax advantages of depreciation and other expenses. But before getting involved in a syndication, consult the advice of a realtor who is a member of a real estate securities and syndication institute (RESSI) and your attorney. You should also seek the advice of your CPA on the recapture provision of the limited partnership sale.

One unique feature of real estate as opposed to other investments is that the investor retains a large amount of control over the amount of income received and amount of money spent in the investment. Even though real estate investment options are affected by external market factors, the investor retains a great amount of control over a number of variables such as rent, interior decorating, modernization, etc. It's a challenging type of investment, because in most cases your hand is on the wheel at all times.

One other point — there are very few "givens" or standards in real estate investing. Even within a particular market area, there are good deals and bad deals based on a variety of factors. It can generally be said, however, that investments grow at a faster pace in higher income areas. The basic premise involved here is that people make value — if they earn more, they are willing to pay more for shelter.

If you're considering real estate investment, talk with a realtor who is a member in good standing of the National Association of Realtors.

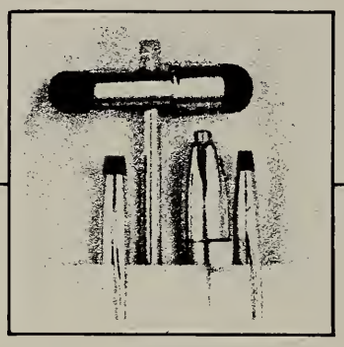
The Realtor Association grants designations to real estate professionals who are accomplished members of societies, institutes and councils in specialized real estate fields. For a broad base of knowledge and experience, contact a member of the American Society of Real Estate Counselors (ASREC). All ASREC members are designated counselors of real estate (CRE). Their services are available on a fixed fee, per diem or retainer basis, not unlike the system used by lawyers and financial consultants.

Other specialized designations include MAI (Member, Appraisal Institute), CPM (Certified Property Manager) and SRS (Specialist in Real Estate Securities).

In today's complicated investment world, diversity is the key. If you're ready to invest, examine your short and long-term investment goals, seek professional advice and consider real estate as an alternative. It could become a valuable and profitable part of your investment portfolio. **OSMA**

Richard L. Royer is a past president of the Ohio Association of Realtors and is a principal of Kohr, Royer & Griffith, a Columbus commercial-investment real estate firm.

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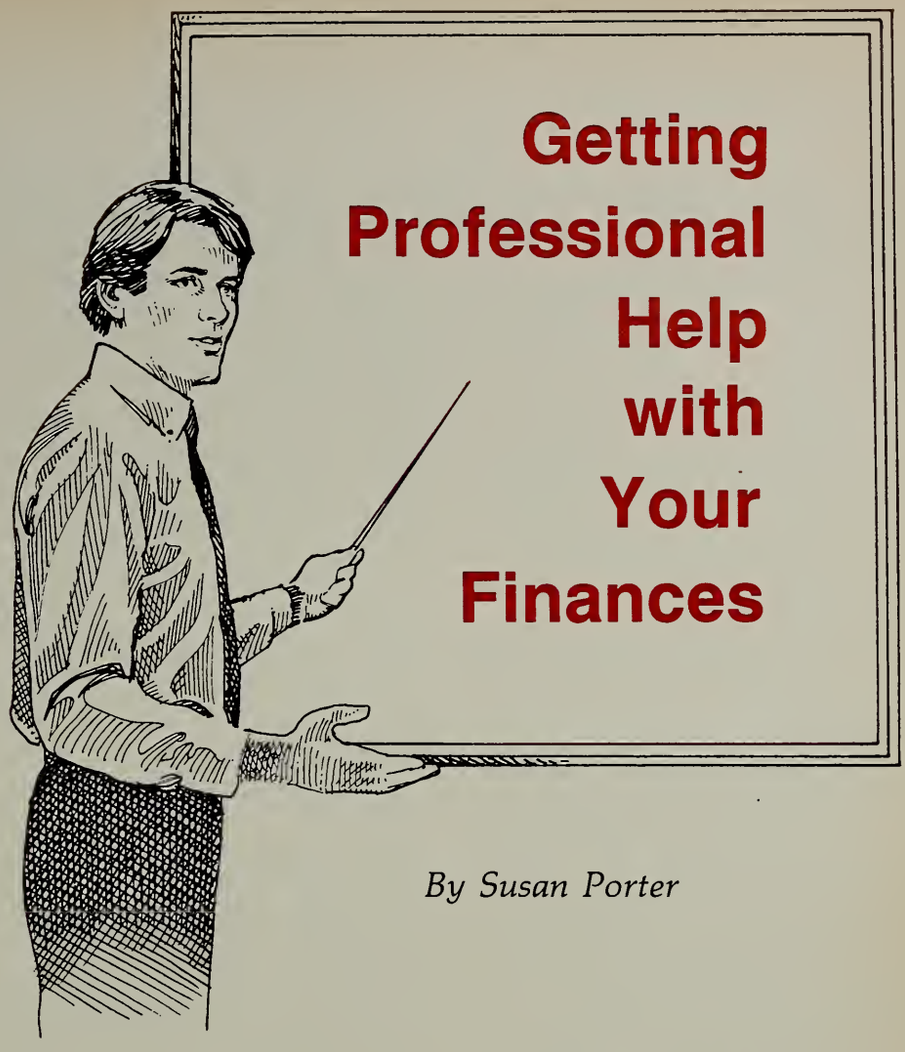
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Getting Professional Help with Your Finances

By Susan Porter

Perhaps you're new in practice and you're struggling on a shoe-string budget in order to meet your payroll and to keep up with the payments on your mortgage, equipment and supplies — not to mention your student loans.

Or maybe you're in an income bracket you never dreamed of reaching — but too much of that money is sifting through your pockets into taxes.

Or retirement is in your foreseeable future, and you're thinking about investing in a sideline activity — horses, farming, real estate, antiques — a hobby today, that could blossom into a small business enterprise tomorrow, when you'll need some supplemental income.

No matter what your circumstances, chances are you could benefit from the services of a professional financial planner — someone specially trained to sit down with you and look over all of your financial assets and liabilities, from your insurance policies and pension portfolio, to the way your practice is structured and the taxes that you're paying.

Like a patient suffering silently from an unknown disease, the sooner you seek professional help, the better. And like that patient who wants the best care possible, a good deal of thought, time and consideration should go into your choice of assistant.

"It's never too early to seek high-caliber help with your finances," says John Sestina, a certified financial planner in Columbus and the head of SMB Financial Services Group.

"Physicians should seek professional advice in their careers as early as possible," he continues, adding that procrastination is the most common financial error made by doctors. "He should get help even before he realizes he needs it. It's like me waiting until I'm in pain before calling the doctor. By then, it may be too late."

Not only should physicians begin financial planning early in their careers; they also need to make regular financial check-ups a top priority if they wish to maintain financial health.

"Many doctors simply don't give their financial lives the ongoing attention they need," says Sally Gries, a certified financial planner who works regularly with physicians in the Cleveland area. "Doctors are so focused in their specialties and have such a keen interest in their work that they don't have the time to take care of the money they earn."

"It's never too early to seek high-caliber help with your finances."

Part of the problem, both Sestina and Gries agree, is that because physicians are so used to being in charge of their own practices, they often are reluctant to seek help from outsiders. Says Sestina, "They're so used to making all of the decisions, themselves, that they think everyone expects them to be brilliant at everything. They think they're supposed to be perfect in all areas."

Yet physicians, as a group, need more help with their money than most individuals, financial advisers agree. "They typically make more income than the average person," says Sestina, "and they're also busier in their work. And most are responsible for 100% of their own financial needs, both now and in the future. The corporate counterpart at GM has someone else setting up his pension program and investing the profits. The physician has to take care of all of that himself."

Because the current financial environment is so complex, "It's a full-time job for even a professional planner to keep up with it," Gries points out. "Most doctors have the capacity to make good financial decisions, but they need someone who can take the time to study and present all of the alternatives — to give them the vision they need to make those decisions. That is the role of the financial planner — to give them that vision."

Charles Crumrine of Confidential Planning Services in Middletown, a financial planning firm which works with the Academy of Medicine in Cincinnati to help member physicians

Getting Professional Help

continued

with their finances, concurs. "Doctors are very busy in their professions — they are the experts at what they do, just as we are the experts at what we do," he says.

Although some physicians work regularly with other professionals — attorneys, tax consultants, insurance counselors, stock brokers, CPAs, etc. — to get help with their finances, this does not replace the need for an overall financial planner whose goal is to focus on the total financial picture, says Crumrine.

"We're not there to replace other advisers — we're there simply to help coordinate their activities — to tie together all of these different aspects and to give the client an objective overview of his finances."

To date, Cincinnati's program has geared itself chiefly toward the financially well-established physician who already has an extensive investment portfolio and is simply looking for more lucrative ways to arrange it. However, the Academy currently is planning a new program designed for the physician just beginning a practice, as well as the doctor who is still in the middle-income range.

"We're hoping to put together a two or three phase program which will help the physician at every level of his career," Crumrine says. "The first phase would be for the doctor in his 30s who's more interested in finding out how to pay off all of his debts than in building an investment portfolio."

The intermediary program would be for the doctor "who is on his way to financial success, but not quite there yet." And the third phase is for the doctor "who has so many investments, he has trouble keeping track of all of them," says Crumrine.

While a number of financial planning programs are aimed at the successful physician (some financial planners will not even work with an individual whose personal income is below $100,000), Sestina agrees there is a critical need for early financial counseling. In fact, the most important dollars, he says, may be the first ones earned.

"Often times, a doctor will struggle for two or three years, and when he finally starts to see some real income, he rewards himself prematurely," Sestina explains. "He buys too big a house or too big a car, or he sends his kids to a private school too soon. All of this can come later, but if he begins spending his assets too soon, it can hinder his entire financial future.

"A lot of folks say that when you're young, you can afford to make mistakes, you can afford to lose," Sestina continues. "This is a big misconception. If a doctor messes around with his money his first few years in practice, it can cost him thousands of dollars 30 years later — at retirement time, when he may need it the most."

Because the current financial environment is so complex, "It's a full-time job for even a professional planner to keep up with it."

So how does one go about seeking a qualified financial planner? Because the field is still relatively new and credentials are somewhat limited, a good place to begin is to ask for recommendations from other professionals who have used such a service — not only other physicians, but also bankers, lawyers, CPAs and others with day-to-day dealings in the financial world.

Background and education also are important considerations. Sestina says a master's degree in financial services is one degree now offered, along with designations such as Certified Financial Planner or Chartered Financial Consultant, both of which indicate a certain level of competency, education and experience has been achieved.

Gries suggests selecting someone with "a strong background in investments — preferably someone who has been admitted to the registry of the International Association of Financial Planners."

Crumrine, on the other hand, says, "It's the organization behind the individual that's important — the back-up people with the expertise. Physicians should seek out a network of counselors who have the ability to call upon the expertise of a lot of people."

All three emphasize that physicians should seek out financial counselors with a lot of experience working with physicians' finances. "Doctors are unique," says Sestina. "Yet most professionals are trained to look at finances from a certain perspective — a perspective that may or may not work for doctors."

It is for this reason that Physicians Insurance Company of Ohio (PICO) recently formed the PICO Financial Services Group, which offers not only financial planning services through SBM Financial Planning, Inc., but also has two other divisions. One, PICO Investment Management Services, Inc., offers counseling and portfolio management services in the areas of personal and corporate investments, pension development and other investment-related activity, according to Howard Trickett, director of marketing for American Physicians Life, a subsidiary of PICO. The other, the Pension Division of American Physicians Life, specializes in designing, installing, servicing and administering pension programs for individuals and corporations.

Once you have compiled a list of potential counselors or planning services, it is wise to set up a personal interview with each of the most promising before making a financial selection. Rather than fully disclosing your own financial circumstances, you may want to start out by posing some hypothetical questions and situations to see how the planner's responses coincide with your own financial philosophy. In most cases, there will be little or no fee for this initial consultation.

It is also important to know and understand how the adviser expects to

be reimbursed, as this will impact to some degree on the kind of advice the planner is prepared or motivated to give (see related sidebar).

You should also establish from the beginning at what intervals you will be meeting with your planner, how often your account is to be reviewed, how often statements will be issued to you and in what format they will be issued.

While a lot of physicians prefer a you-take-care-of-it-and-call-me-if-there's-a-problem attitude towards their finances, it's important that the client take an active role in his/her financial future, every step of the way, according to Gries. "Today, especially, physicians really need to be on top of things," he says. "With DRGs and all, there are continuous changes in the financial climate. We generally see and talk to our clients several times a quarter."

Sestina points out that the recently passed *Deficit Reduction Act of 1984* will bring about major changes in the financial practices of many physicians, and adds, "Physicians need to touch base with their financial advisors as soon and often as possible," Also, they should be working at least a year ahead to insure their fiscal well beings.

"You can't wait until April of 1985 to reduce your 1984 taxes — by then, it's too late," says Sestina.

Income taxes are the single largest reason physicians seek professional advice, all three planners relate. Yet tax shelters are only one small part of the physician's overall financial investment picture. Unfortunately, many physicians are drawn into tax-advantage investments without really stopping to look at that total picture, Gries has discovered.

Her advice is to "look at the value of the investment in terms of what it will do for your net worth, as well as what it will do for your tax bill. An investment should make a lot of sense economically, as well as offer a tax advantage," she says.

Sestina calls the syndrome "letting the tax-shelter tail wag the economic dog," and explains, "All physicians assume they're paying too much in taxes. But many are actually well

The fee-only planner

By John E. Sestina

Over the last few years, the battle lines have been drawn between financial planners who work exclusively on a fee-for-service basis and those consultants who also sell products.

The general uneasiness that continues between fee-only financial planners and those who sell commissionable products as part of their services today is fueled by misunderstanding. There is room for both kinds of financial planners in the marketplace. The decision between the two depends on what the client needs and what will work best in his/her individual situation.

For example, a planner who sells a variety of products can perform a valuable service if the client is exceptionally knowledgeable and knows what questions to ask to effectively evaluate different kinds of proposals. The client's options may be very limited, however, if the planner offers only one kind of each type of product.

On the other hand, if a client is not familiar with one or more areas of financial management and does not want to take the time to learn about them, his or her best bet may be with a fee-only planner who will think of the client's goals ahead of selling products.

That, incidentally, was one reason why a professional association called the Society of Independent Financial Advisors (SIFA) was formed in 1975 — to help educate the general public about the kinds of financial planning services available.

The principal advantages the fee-only financial planner brings to the marketplace are objectivity, thoroughness and flexibility.

Because the client pays for advice on much the same basis as, say, for legal guidance, the fee-only planner is solely concerned with the client's interest and not with which product pays the highest commissions.

This kind of planner also takes a good hard look at everything in a client's financial life — not simply investments or insurance. For example, an investment portfolio may be in great shape, but problems may exist tax-wise or in planning the transfer of an estate.

Because the fee-only planner looks at the whole financial picture for a client — not just an isolated part of it — there is an incentive to work just as hard at solving problems that do not normally involve a financial product, such as non-investment ways to save taxes. And because fee-only planners are compensated for their time, they can structure their services to include assistance that does not relate to purchase of a product, such as budgeting, personal cash flow projections, and building cash reserves. The idea of a plan geared solely toward a client's own goals — one that is comprehensive and constantly monitored — is often a major attraction.

Fee-only planners also offer the flexibility of purchasing virtually any financial product on the market and structuring opportunities that may not be available otherwise. For instance, a fee-only planner with a reputation for independence, may be approached directly by entrepreneurs seeking financing. This gives him or her the leverage to help a client take advantage of an opportunity less expensively — by eliminating a 10% to 15% commission — and to help structure the investment increments to fit the client's situation.

Usually, the financial planning fee — which should be determined prior to any indepth analysis — is tax deductible, except for the portion on estate planning. (That seems to be attractive for clients in the 50% tax

continued on page 725

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Getting Professional Help

continued

below the 50% bracket." As a result, he says, "Many doctors are an easy mark for tax shelter deals."

Yet, Sestina adds, "I don't like the phrase 'doctors are bad businessmen' — it's absurd to assume that anyone who is successfully practicing medicine couldn't do just as well with his finances — assuming he spent the same amount of time and energy on them that he does on medicine. The truth is, in most cases, there isn't time for both."

Yet taking time is important. Even if you and your financial planner see eye-to-eye on most aspects of your financial future, it's important to realize that the best thought-out plans contain risk. Thus, the more homework you do both before and after selecting a planner, and the more involved you are in the process, the less likely you are to be greeted by surprises when April 15, 1985 roles around. **OSMA**

Susan Porter is Assistant Editor of the Ohio State Medical Journal.

The Fee-Only Planner

continued

bracket.) Fee-only planners determine the price of their services by various methods, although the fee is usually related to annual income and that portion of a client's total assets under management. It is important to stress that today's fee-only planners do not necessarily compete with those who sell products. In fact, in many instances, they may work together to find a financial product appropriate to a client's needs. The prudent planner has excellent relationships with many commissioned salespeople because the planner can refer pre-qualified and prescreened buyers to him/her if he/she has the right product to solve the client's problem.

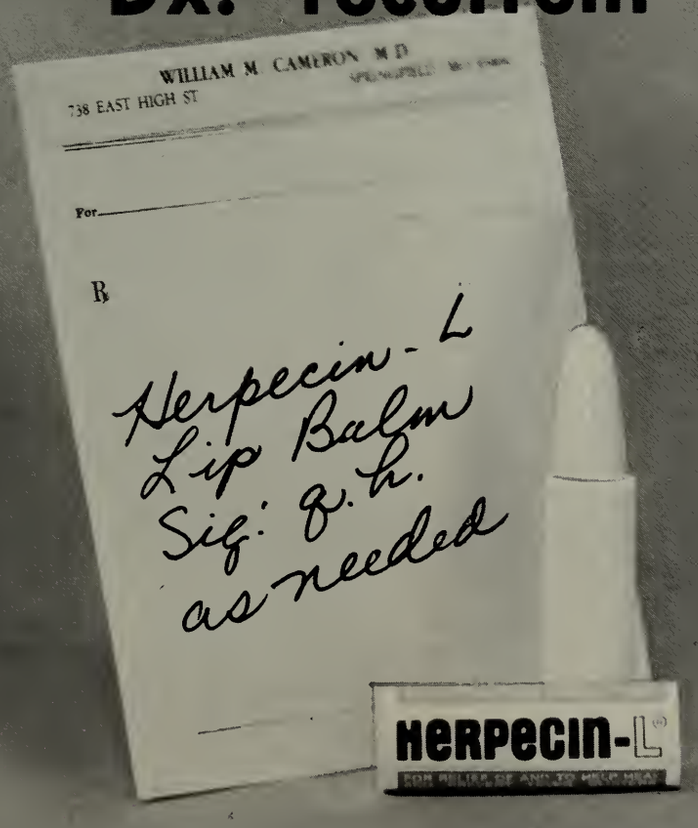
Another role of the financial planner is to encourage all of the client's professional advisors, including his/her attorney and accountant, to work together as a team to meet the goals the client has set forth. Commissioned salespeople may also be part of that team effort. Salespeople are an important part of the planning flexibility the planner can offer a client. After a planner studies and recommends a proposal, the salesperson gets his/her commission and the client gets what he/she needs, so everyone wins.

In summary, in deciding between using the fee-only financial planner or the individual who sells commissionable products as part of his or her service, the interested client must assess his specific needs and goals and make a decision based on his or her comprehensive financial planning future.

Whatever course of action you decide to undertake, make sure you understand the services and limitations of each type of consultant available to you. **OSMA**

John E. Sestina is a certified financial planner in Columbus.

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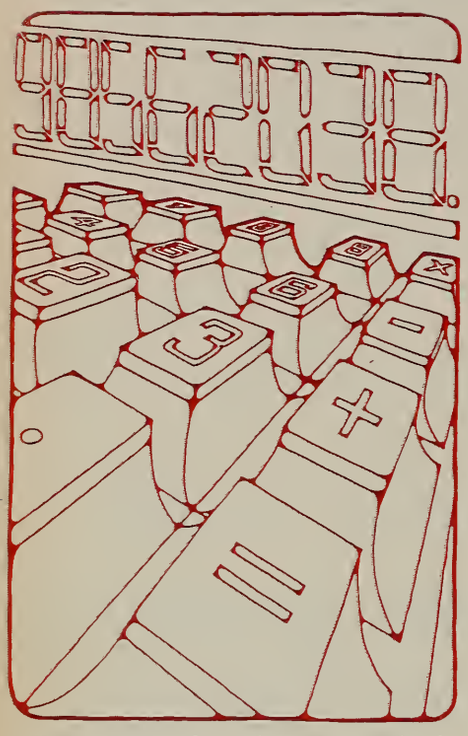
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Putting a Pricetag on a Practice:

A Look at Both Sides

By Jack Valancy

Determining the value of a medical practice can be an anxious process for both the seller and the buyer. Typically, the seller is a senior physician about to retire from active practice. The buyer, on the other hand, is usually a young physician who is looking to become established. They have a mutual interest in arriving at a fair price: The seller does not want to receive any less and the buyer does not want to pay any more.

Unfortunately, neither physician may have much experience in putting a pricetag on a practice. There is no simple formula for doing this. Many factors must be considered, the importance of which depends upon the perspective of the parties. A factor which is significant to the seller may be irrelevant to the buyer, and vice versa. For this reason, a comprehensive approach which considers both the tangible and intangible aspects of the practice is recommended.

Tangible Assets

Tangible assets refer to the physical property of the practice: office space, equipment and furniture, supplies and medications, and accounts receivable. Here are some guidelines for converting these to a cash price.

•Office Space

If the office space is presently being leased, the selling physician may be able to sublet the suite to the buying physician at a small profit. The amount of this profit will depend upon the going rates in the area for similar space. If the building is a desirable one, this could work to the advantage of both physicians, with the seller making some money and the buyer saving some. If the building is not fashionable, though, the seller may have a hard time justifying a rent that is above current market conditions. These conditions are even more important if the office space is to be sold. In this case, it is best to use the services of an experienced, qualified Realtor in order to arrive at an appropriate price.

The improvements within the suite, such as interior walls, built-in cabinetry, plumbing, wall and floor coverings, will affect the price, as well. The design of the office and its condition may be critical to the buyer; can the office be used "as is," or will additional improvements be required before the new physician may begin practicing? Obviously, a buyer will be less inclined to pay a premium price if walls must be rearranged or if the suite has not been redecorated in twenty years.

•Equipment and Furniture

The value of equipment and furniture depends upon its age, condition, and usefulness to the new doctor. Each price should be listed on a schedule in order to establish exactly what is included in the sale. With the exception of special purpose equipment, used items may be sold for anywhere from book value to about 80% of its replacement cost. (Book value is the original cost of the item less accumulated depreciation as recorded in the practice's accounting system.) Since there may be a very wide range between the two, a professional appraiser or equipment and furniture sales representative may help to estimate the fair market value of each item.

•Supplies and Medications

In most practices, the value of supplies and medications is not more than a few thousand dollars. One way to save the time and trouble of an item-by-item inventory is to:

— estimate the number of months worth of supplies and medications currently on hand, typically about two months worth.

— use this to pro rate the practice's annual supplies and medications expense.

— multiply this by a replacement cost factor (60% to 80%) which

allows for items the new doctor may not wish to use.

Clearly, the selling physician hoping to get the most for his or her practice's tangible assets should look for a prospective buyer who expects to operate the practice in a similar manner. Conversely, the buying physician hoping to get the best value for his or her money should carefully consider the potential utility of each tangible asset.

•Accounts Receivable

There are three basic ways to dispose of the practice's accounts receivable:

— The seller may retain them and continue collection efforts.

— The buyer may liquidate them for the seller. In this case, the buyer receives a fee for this, usually 10%-20% of the amounts actually collected.

— The buyer may purchase the accounts receivable outright. There are many different formulas for calculating their value. One such way of arriving at a selling price is to:

* reduce the total by eliminating the value of all of the old, uncollectable accounts, such as those over six months old.

* multiply the balance by the practice's collection ratio, i.e. the percentage of gross fees actually collected.

* reduce the product by the estimated cost of the collection efforts, usually 10%-20%.

Intangible Assets

Patients are the practice's most important intangible asset. Anything the seller can do to assure continued loyalty from existing patients and new patients from referral sources will increase the value of the practice to the buyer. A careful analysis of the patient population and referral sources will be helpful to both parties.

In addition to the total number of active patients in the practice, consider the age distribution and the types of cases that are being treated. Is this population appropriate for the buying physician? For example, an internal medicine practice with a predominantly elderly patient population may not be as attractive to a prospective buyer as one with a population distributed over all ages. (The exception to this being a physician who intends to specialize in geriatrics.)

The practice of a physician who has been winding down his or her career may not be as active as that of a physician who continues to maintain a full schedule. How busy is the practice? Are new patients being added to the practice? Are the cases challenging or routine? In short, is the practice a "going concern?"

Evaluate the demographics of the community the practice serves. For example, an obstetrician or pediatrician would be advised to select a community with many young families than one with an aging population. In addition to patients, evaluate the competitive situation in the area. Physicians tend to flock to certain areas and bypass others. It can be very stressful to establish a practice in an area which is saturated with physicians. Adjacent communities may have greater potential.

Many practices rely quite heavily on referrals. The selling physician has earned the confidence and respect of the referring physicians based upon years of experience. This, along with the confidence and respect of his or her patients, constitutes the selling physician's "goodwill." Obviously, a reduction in the number of referrals reduces the value of the practice to the buyer.

Goodwill is valuable to the buying physician only to the extent that some of it can be transferred to him or her. The best way to affect this transfer is for the selling physician to continue in the practice for several months alongside the buying physician. This conveys the selling physician's implicit approval of the buying physician to patients and referral sources. To reinforce this, the selling physician should actively introduce the buying physician to patients and referral sources.

While there are several alternative methods for the buyer to pay the seller for goodwill, setting a price on the patient records is not one of them.

According to the Current Opinions of the Judicial Council of the American Medical Association, 1981, (7.04): "A physician retiring from practice may not ethically sell his patients' records to another physician. His records have been developed during the physician-patient relationship. To sell records would make the patient subject to barter to the highest bidder." Patients should be informed that their medical records will be transferred to the physician of their choice upon written request. The physician transferring the records may charge a small fee for administrative costs.

In most cases, identifying goodwill on the sales agreement is not advisable for tax reasons. In some cases, the price of the practice's tangible assets are increased to compensate for goodwill. Other times, it may be best for the selling physician to receive a professional fee for serving as a consultant to the practice. Physicians should consult with their tax advisors for guidance in this area, as the best tax strategy depends upon the specific situations of the parties involved.

The Bottom Line

No two medical practices are exactly alike. Both physicians should approach the process in a calm, unhurried manner. They should carefully examine the factors. Their objective should be an agreement which is mutually satisfactory. It is better to find someone else than to force a deal. In the end, the correct price of a practice is what a willing buyer is prepared to pay a willing seller. **OSMA**

Jack Valancy heads a health care management consulting firm in Cleveland Heights, Ohio.



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Proceedings of the 1984 Annual Meeting

Minutes of the Final Session

Editor's Note: *The minutes of the first session of The OSMA House of Delegates appeared in the September issue of* **The Journal.**

The final session of the House of Delegates was convened at 1:00 PM, Sunday, May 20, 1984, at the Cincinnati Convention Center, with President S. Baird Pfahl, Jr., M.D., presiding.

Honored Guests

Dr. Pfahl announced that two out-of-state guests were present at the Final Session of the House: Dr. Carl R. Adkins, President of the West Virginia State Medical Society; and Dr. Donald C. Barton, Chairman of the Board, Kentucky Medical Association.

Introduction of OSMA Past Presidents

Dr. Pfahl introduced the following Past Presidents who were not present at the First Session of the House: Dr. Robert N. Smith, Toledo, and Dr. Robert G. Thomas, Elyria.

Dr. Ford Presides

Dr. Pfahl received the permission of the House for Dr. C. Douglass Ford to preside over a portion of the meeting.

Dr. Ford asked Mrs. Fifi Pfahl to come forward. Dr. James Hart escorted Mrs. Pfahl to the podium to join Dr. Pfahl. Mrs. Pfahl was inaugurated Friday as President of the OSMA Auxiliary while Dr. Pfahl would in a matter of hours become Past President of the OSMA. However, for the moment man and wife were the chief elected officers of the two closely related organizations. Mrs. Pfahl addressed the House.

Report of the Credentials Committee

Dr. Ford yielded the chair to Dr. Pfahl who called for the report of the Committee on Credentials.

Dr. Luther W. High, Millersburg, Chairman of the Committee, reported that out of 230 delegates eligible to vote, 195 were present, credentialed and seated.

Election of President-Elect

Dr. Pfahl called for nominations for the office of President-Elect. Dr. W.J. Lewis, Dayton, placed in nomination Dr. Herman I. Abromowitz, Montgomery County, Councilor of the Second District. The nomination was seconded by Dr. Oscar W. Clarke, Gallipolis. There were no other nominations and Dr. Abromowitz was elected by acclamation. Dr. Abromowitz presented a brief statement and was seated at the head table.

Dr. Pfahl introduced Mrs. Abromowitz to members of the House.

Report of Nominating Committee

Dr. James F. Clements, Delegate, Richland County, Chairman of the Nominating Committee, presented the report of the Committee on Nominations as follows:

Councilors

First District: As Councilor of the First District, to succeed himself, Dr. John E. Albers, Cincinnati, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Albers was declared reelected Councilor of the First District for a term of two years, 1984-1986.

Third District: As Councilor of the Third District, to succeed himself, Dr. Thomas R. Leech, Lima, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Leech was declared reelected Councilor of the Third District for a term of two years, 1984-1986.

Fifth District: As Councilor of the Fifth District, to succeed himself, Dr. Donavin A. Baumgartner, Jr., Cleveland, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Baumgartner was declared reelected Councilor of the Fifth District for a term of two years, 1984-1986.

Seventh District: As Councilor of the Seventh District, to succeed Dr. H. Judson Reamy, New Philadelphia, the Committee placed in nomination Dr. Nermin D. Lavapies, Martins Ferry. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Nermin D. Lavapies was declared elected Councilor of the Seventh District for a term of two years, 1984-1986.

Ninth District: As Councilor of the Ninth District, to succeed himself, Dr. Thomas P. Price, Jr., Gallipolis, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Price was declared reelected Councilor of the Ninth District for a term of two years, 1984-1986.

Eleventh District: As Councilor of the Eleventh District, to succeed himself, Dr. D. Ross Irons, Bellevue, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Irons was declared reelected Councilor of the Eleventh District for a term of two years, 1984-1986.

Second District: As Councilor of the Second District, to succeed Dr. Herman I. Abromowitz, Dayton, the Committee placed in nomination Dr. William J. Marshall, Dayton. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. William J. Marshall was declared elected Councilor of the Second District for a term of one year, 1984-1985.

AMA Delegates

Dr. Clements then presented the nominees for the office of Delegate to the American Medical Association to serve a term beginning January 1, 1985 and ending December 31, 1986 (7 to be elected): Dr. Theodore J. Castele, Cleveland; Dr. Stewart B. Dunsker, Cincinnati; Dr. Jerry L. Hammon, Dayton; Dr. H. William Porterfield, Columbus; Dr. Jack Schreiber, Canfield; Dr. Robert N. Smith, Toledo; and Dr. Robert G. Thomas, Elyria. The nominations were duly seconded and there were no further nominations from the floor. The nominees were elected unanimously, by acclamation.

Dr. Clements explained to the members of the House that due to a gain in membership, Ohio was entitled to an additional Delegate and presented the nominee for the office of Delegate to the American Medical Association to serve a term beginning immediately and ending December 31, 1985: Dr. Ray W. Gifford, Jr., Cleveland. The nomination was duly seconded and there were no further nominations from the floor. Dr. Gifford was elected unanimously, by acclamation.

AMA Alternates

For Alternate Delegate to the American Medical Association to serve a term beginning January 1, 1985 and ending December 31, 1986, the nominees were (6 to be elected): Dr. A. Robert Davies, Troy; Dr. Roland A. Gandy, Jr., Toledo; Dr. Edward G. Kilroy, Cleveland; Dr. S. Baird Pfahl, Jr., Sandusky; Dr. Carl E. Spragg, New Concord; Dr. Joseph Sudimack, Jr., Warren; and Dr. Claire V. Wolfe, Dublin. The nominations were duly seconded and there were no further nominations from the floor.

A motion was made to amend the Committee's report asking for the election of 6 Alternates and to change this asking for the election of 7 Alternates instead. The motion was defeated.

A written ballot was taken and Drs. Davies, Gandy, Kilroy, Pfahl, Sudimack and Wolfe were declared elected.

Report of Resolutions Committee No. 1

Dr. Stanley J. Lucas, Hamilton County, as chairman, presented the report of Resolutions Committee No. 1:

Mr. President and members of the House of Delegates. Resolutions Committee No. 1 held hearings on Resolutions No. 1-84 through 22-84. The testimony by OSMA members was concise and articulate and

was of great assistance to the Committee.

RESOLUTION 1-84 — REVISED VOTING PROCEDURE

Resolution 1-84 as printed in the handbook contained inconsistencies.

The Committee proposes Substitute Resolution 1-84. It is the opinion of the Committee that the adoption of the following Substitute Resolution would significantly speed up without interfering with the election process.

SUBSTITUTE RESOLUTION 1-84 REVISED VOTING PROCEDURE

Whereas, The election of AMA delegates and alternate delegates to the AMA House at the 1982 OSMA House of Delegates took over six hours; and

Whereas, The Council surveyed the members of the OSMA House of Delegates on possible changes in voting procedures used in electing delegates and alternate delegates to the AMA; and

Whereas, Sixty-one (61) of the one hundred fifteen (115) delegates responding supported changing the procedure to drop the two candidates receiving the lowest number of votes until there are two more nominees than positions to be filled; THEREFORE BE IT

RESOLVED, That Chapter 5 Section 7 of the Bylaws be amended as follows:

In the event there is only one position to be filled, the nominee receiving the majority of all votes cast shall be declared elected. In case no nominee receives a majority on the first ballot, the two nominees receiving the lowest number of votes shall be dropped and a new ballot taken; this procedure shall be continued until there are two nominees remaining. The nominee receiving a majority of all votes cast shall be declared elected.

In the event there is more than one position to be filled from among any number of nominees, a nominee, in order to be declared elected must receive the votes of a majority of those voting, provided, however, that if upon any ballot the number of nominees receiving a majority vote is greater than the number of positions to be filled on such ballot, those nominees (not to exceed the number of positions to be filled on such ballot) receiving the greatest number of votes shall be declared elected. If upon any ballot some but not all of such positions are filled, a new ballot shall be taken from among all of the remaining nominees; except that the two nominees receiving the lowest number of votes on the previous ballot shall be dropped on each new ballot until there are two more nominees than positions available, after which the nominee receiving the lowest number of votes shall be dropped. On every ballot a nominee, in order to be declared elected, must receive the votes of a majority of those voting, provided, however, that if upon such new ballot the number of nominees receiving a majority vote is greater than the number of positions to be filled on such ballot, those nominees (not to exceed the number of positions to be filled on such ballot) receiving the greatest number of votes cast shall be declared elected. If upon any ballot no nominee receives the votes of a majority of those voting, the TWO nominees receiving the lower number of votes shall be dropped and a new ballot will be taken; this procedure shall be continued until there are two more nominees than positions available, after which the nominee receiving the lowest number of votes shall be dropped: and this procedure shall be continued until all positions have been filled.

The Committee recommends adoption.

By official action, *the House adopted Substitute Resolution 1-84.*

RESOLUTION 2-84 — SINGLE SHOT VOTING

The Committee heard testimony regarding the pros and cons of banning "single shot voting" and is of the opinion that there is a balance between the advantages and disadvantages. It was pointed out that perhaps a better approach to the problem might be in a reevaluation of the nominating process. Resolution 2-84 is before the House. The Committee recommends rejection.

By official action, *the House voted to reject Resolution 2-84.*

RESOLUTION 3-84 — DUES INCREASE

The preponderance of testimony indicated a true need for maintaining the strength and effectiveness of the OSMA and its services to physicians and the community.

Because of the current and projected financial needs of the OSMA the Committee felt Resolution 3-84 should be passed at this time. Resolution 3-84 is before the House. The Committee recommends adoption.

Resolution 3-84 reads as follows:

Whereas, inflation outpaced the 15% OSMA dues increase in 1980; and the OSMA has continued to provide services to its members despite budgetary constraints; and,

Whereas, the OSMA has exhaustively sought non-dues revenue, which now represents 30% of the association's income, to supplement the dues and keep the members' dues rate at the lowest level; and,

Whereas, Ohio is considered among the top state medical associations in the country with vigorous programs to meet members' needs, but ranks fortieth in its current dues-rate assessed to its members; and,

Whereas, the OSMA will be using its only reserve to fund a budget deficit in 1984, and it must continue to meet the onslaught of challenges brought about by changing attitudes of the public and government concerning the provision of medical care; and,

Whereas, representation of the members continues to increase at the legislature, with state and federal rule-setting bodies, the state medical board, the media, the public, the membership and with third party payers; and,

Whereas, the OSMA must be ready to respond on behalf of its members to health care issues such as DRGs, alternative health care delivery systems, changes in hospital medical staff and competition; and,

Whereas, the OSMA can only maintain its position as the spokesman for the physicians of Ohio under the umbrella which unites all specialties of practice, residents, and students of medicine with adequate financial resources, THEREFORE BE IT

RESOLVED that the dues of the Ohio State Medical Association be increased by one hundred dollars over a three-year period in the following increments: from $195.00 to $250.00 for dues-year 1985; from $250.00 to $275.00 for dues-year 1986; and from $275.00 to $295.00 for dues-year 1987 and thereafter.

By official action, *the House adopted Resolution 3-84.*

RESOLUTION 4-84 — OMGMA MEMBERS AS OSMA AFFILIATE MEMBERS

Office managers have the same concerns regarding third party payers and government regulations as their physician employers. The Committee was of the opinion that significant positive benefits would arise from a close relationship between the office managers and the OSMA. Resolution 4-84 is before the House. The Committee recommends adoption.

By official action, *the House rejected Resolution 4-84.*

RESOLUTION 5-84 — ESTABLISHMENT OF HOSPITAL MEDICAL STAFF SECTION

There is increasing physician allegiance and identification with their hospital medical staffs. The Committee is of the opinion that the establishment of a section in the OSMA would fulfill a need for improved participation and communication between the two; therefore the Committee recommends adoption.

Resolution 5-84 reads as follows:

Whereas, at its 1983 Annual Meeting, the American Medical Association House of Delegates adopted Resolution 149 — "Establishment of State Hospital Medical Staff Sections." Resolution 149 said:

"Resolved, that the American Medical Association House of Delegates encourage every state medical association to establish a statewide hospital medical staff section;" and

Whereas, the OSMA House of Delegates at its 1983 Annual Meeting instructed the Council to establish a Committee on a Hospital Medical Staff Section to monitor activities until the 1984 Annual Meeting; THEREFORE BE IT

RESOLVED, that the House of Delegates instructs the Council to establish an OSMA Hospital Medical Staff Section; and be it further

RESOLVED, that the Hospital Medical Staff Section meet prior to the Annual

Meeting of the Association to elect a delegate to the Annual Meeting; and be it further

RESOLVED, that the OSMA Constitution and Bylaws be amended as follows:

Constitution Article IV House of Delegates

(page 2, column 1, second paragraph) . . ., but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the student member of each medical school elect their own delegate; the hospital medical staff section shall have one representative to the House of Delegates commencing with the annual meeting in 1985, said delegate to be selected in accordance with bylaws of the medical staff section to be approved by council: (4) delegates and alternate delegates . . .

Bylaws Chapter 4 The House of Delegates Section 4 Representative of Hospital Medical Staff Section

The hospital medical staff section shall have one delegate and alternate delegate who must be active members of the Ohio State Medical Association. In case a delegate or alternate delegate is unable to serve, the chairman of the section may at any time certify to the chairman of the committee on credentials the name of an active member of the association to serve in place of the absent delegate or absent alternate delegate. The committee on credentials shall rule on the eligibility of such certified individual or individuals to act in the place and stead of such absent delegate or alternate delegate.

The hospital medical staff section delegate shall have all rights, privileges and duties as other delegates. The delegate will be seated in the House of Delegates with the councilor district in which his/her county medical society is represented.

Previous Section 4 through 10 to be renumbered.

By official action, *the House adopted Resolution 5-84.*

RESOLUTION 6-84 — NON-DISCRIMINATORY PAY INCREASES FOR PHYSICIAN SERVICES

The Committee is acutely aware of the inadequacies and discrepancies in Medicaid reimbursement policies. The Committee is of the opinion that the following substitute resolution most clearly states the position of our membership:

SUBSTITUTE RESOLUTION 6-84 MEDICAID REIMBURSEMENT REVISION

Whereas, there have been cost of living increases for all levels of state bureaucracy over the last 15 years; and

Whereas, there have been cost of living increases for recipients of welfare funds over the last 15 years; and

Whereas, physician reimbursement has not been increased; and

Whereas, in 1983 physician reimbursement was actually reduced by 5%; and

Whereas, this represents discrimination; and

Whereas, some insurance carriers have indicated they will no longer tolerate cost-shifting to subsidize government programs; THEREFORE BE IT

RESOLVED, That the OSMA request the State of Ohio to review, revise and update Medicaid ~~REIMBURSEMENT~~ REGULATIONS so that there is no interference in the access and quality of care given to Medicaid recipients.

The Committee recommends adoption.

By official action, *the House voted to make a minor amendment in the resolution, as indicated in capital letters and a deletion as noted, and to adopt it as amended.*

RESOLUTION 8-84 — HOSPICE CARE REGULATIONS

The Committee heard considerable testimony on Resolution 8-84. The Committee is of the opinion that the resolution needs to be amended in the following manner by deleting in the "Resolved" the words be required and adding the words SHOULD BE PREPARED as follows:

Whereas, the new federal regulations concerning hospice care provide that each such organization specifically contract with a hospital or hospitals for any in-patient care when needed for patients enrolled in their program; and

Whereas, this will often mean that the patient's personal physician controlling the care, not having privileges in the contracting hospitals, will be unable to continue direct supervision of the patient; and

Whereas, an important aspect of hospice care is the direct personal physician/patient relationship; THEREFORE BE IT

RESOLVED, That the OSMA inform the appropriate governmental agencies of the importance of specifying, in hospice regulations, that any hospital contracting with a hospice organization for inpatient care should be prepared to offer temporary limited privileges to the personal physician of the patient while such patient receives inpatient hospital care and that this resolution be forwarded to the American Medical Association.

The Committee recommends adoption.

By official action, *the House adopted Amended Resolution 8-84.*

RESOLUTION 9-84 — MEDICAL CARE FOR THE ELDERLY

The information available to the Resolution Committee indicates that the AMA Council on Legislation and the Council on Medical Services are actively addressing the intent of this resolution. There is, therefore no need for this resolution and the Committee recommends rejection.

At this time, a Substitute Resolution was introduced as follows:

SUBSTITUTE RESOLUTION 9-84 MEDICAL CARE FOR THE ELDERLY

Whereas, the American Medical Association has long supported the position that all people should have access to the best available medical care regardless of ability to pay; and

Whereas, Congress, when it enacted Medicare, promised a health care program for a growing segment of society based on age, regardless of need; and

Whereas, it is projected that the population, age 65 and older will increase by 31% between the years 1982 and 2000 and more rapidly in subsequent years; and

Whereas, the financing of a government health care program for a growing segment of our society, regardless of need places an increasing financial burden on a younger segment of our population; THEREFORE BE IT

RESOLVED, that the OSMA commend the AMA for its ongoing concern for the health care of the elderly and encourage the continuation of activities designed to maintain and improve high quality reasonably priced care for the elderly of this country.

By official action, *the House adopted Substitute Resolution 9-84.*

RESOLUTION 10-84 — OSMA CONDEMNATION OF DRGS RESOLUTION 15-84 — ASSESSMENT OF DRGS

The Committee considered Resolution 10-84 in conjunction with Resolution 15-84 inasmuch as the subject content was similar. The Committee recommends the following substitute in lieu of Resolution 10-84 and 15-84 as follows:

SUBSTITUTE RESOLUTION 10-84 DRGS

BE IT RESOLVED, That OSMA support the AMA in closely monitoring the effect of DRG reimbursement on the quality and accessibility of medical care; and be it further

RESOLVED, That the OSMA urges all physicians in Ohio to cooperate *where possible* with their affiliate hospitals to ease the hospitals' financial dilemma with DRG reimbursement programs; and be it further

RESOLVED, That the OSMA condemns any hospital action, which in any way threatens, intimidates, or attempts to infringe upon the staff status of a physician because of his inability to put hospital needs before his patient's needs.

Substitute Resolution 10-84 is before the House. The Committee recommends adoption.

By official action, *the House adopted Substitute Resolution 10-84.*

RESOLUTION 11-84 — OSMA QUALITY OF CARE CLEARINGHOUSE

The Committee was of the opinion that similar programs are in existence through the AMA, the OSMA Ombudsman activities, and other programs. Establishing an additional clearinghouse at this time is not necessary. The Committee, therefore, recommends rejection.

By official action, *the House rejected Resolution 11-84.*

RESOLUTION 12-84 — REIMBURSEMENT BY THIRD PARTY PAYERS RESOLUTION 14-84 — PATIENTS' RIGHT TO ASSIGNMENT RESOLUTION 17-84 — DIRECT

PAYMENT BY INSURANCE CARRIERS TO PHYSICIANS

The Committee discussed Resolutions 12-84, 14-84, and 17-84 together because of their similar subject matter. The following substitute resolution is recommended by the Committee in lieu of Resolutions 12-84, 14-84, and 17-84.

SUBSTITUTE RESOLUTION 12-84
ASSIGNMENT OF BENEFITS

BE IT RESOLVED, That OSMA supports the right of patients to assign payment of medical benefits directly to the physician who supplied the service; and be it further

RESOLVED, That the OSMA encourage all third party payers to make provision for and honor the assignment of medical benefits for direct payment to the physician; and be it further

RESOLVED, That the OSMA pursue passage of legislation in this state to allow a person insured under a policy of health insurance to be able to assign his benefits to a physician provider.

The Committee recommends adoption.

By official action, *the House adopted Substitute Resolution 12-84.*

RESOLUTION 13-84 — ADVANCE PLAN AND THIRD PARTY REIMBURSEMENT PROBLEMS

Because of problems created by third party reimbursement policies and negative implications towards physicians, the Committee recommends the adoption of the following substitute resolution:

SUBSTITUTE RESOLUTION 13-84
THIRD PARTY REIMBURSEMENT PROBLEMS

Whereas, medical societies have fully cooperated with Ohio Medical Indemnity Mutual by providing their physicians with appropriate information concerning the Advance Plan; and

Whereas, medical societies have further publicized the Advance Plan by dissemination of information in their official publications; and

Whereas, despite this cooperation, Ohio Medical Indemnity Mutual has interfered with the physician/patient relationship by refusing to allow the patient to assign the insurance payment directly to the physician; and

Whereas, public advertising and other communications to patients indicate that physicians who do not participate in the Advance Plan are uncooperative and are charging fees which are excessive; and

Whereas, non-participating physicians are experiencing unnecessary delays in the processing of claims and other administrative difficulties. THEREFORE BE IT

RESOLVED, That the OSMA maintain communication with Ohio Medical Indemnity Mutual in an effort to protect the rights of patients of physicians who do not participate in the Advance Plan; and be it further

RESOLVED, That the OSMA oppose any language in third party reimbursement forms and other literature that implies physicians' fees above insurance benefit levels are improper and excessive.

The Committee recommends adoption.

By official action, *the House adopted Substitute Resolution 13-84.*

RESOLUTION 16-84 — COGNITIVE SERVICES REIMBURSEMENT

All the testimony was favorable; the Committee therefore recommends adoption.

Resolution 16-84 reads as follows:

Whereas, all physicians provide a mix of both cognitive and procedural services; and

Whereas, cognitive services can be defined as those services that directly employ the physicians' perception, judgment and knowledge to make a diagnosis and to establish the best course of treatment; and

Whereas, technological procedures involve the use of technology and/or manual skills to obtain clinical data or to treat disease; and

Whereas, most existing reimbursement systems provide disproportionately low allowances for such cognitive services as complete histories and physical examinations, office, nursing home and hospital visits, and medical and surgical consultations in comparison to procedural services; and

Whereas, many technological procedures require considerable cognitive skill and judgment on the part of the physician providing the procedure; and

Whereas, the cognitive skills required to provide those procedures are also reimbursed at a disproportionately low level compared to the actual performance of the procedure; and

Whereas, this reimbursement discrepancy may contribute to high medical costs by rewarding physicians for ordering tests and procedures; and

Whereas, there is a growing body of opinion and research to support the concept that a reimbursement system that better rewards cognitive services might help moderate medical care expenditures and promote the kind of caring, personalized approach to health desired by most patients and physicians alike; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association make it a policy to support the concept that third party payers should provide equitable reimbursement for physicians' cognitive services in comparison with their procedural services; and BE IT FURTHER

RESOLVED, that the Ohio State Medical Association take appropriate action to promote this concept with third party payers, business groups and other professional associations; and be it further

RESOLVED, that the Ohio State Medical Association delegation introduce or support a similar resolution on cognitive services reimbursement at the next meeting of the House of Delegates of the American Medical Association.

By official action, *the House adopted Resolution 16-84.*

RESOLUTION 18-84 — REQUIREMENTS FOR PREADMISSION CERTIFICATION AUTHORIZATION

Information furnished to the Committee indicates that the intent of the resolution is already required under Ohio Department of Public Welfare regulations.

The Committee recommends that the OSMA staff monitor the compliance of the regulations. The Committee therefore, recommends rejection.

By official action, *the House rejected Resolution 18-84.*

RESOLUTION 19-84 — PRESERVING PRIVATE PRACTICE IN COMPETITION

The Committee is aware of the rapid proliferation of alternative health delivery systems and agrees with the necessity of informing OSMA members of these matters. The following Substitute Resolution is recommended:

SUBSTITUTE RESOLUTION 19-84
THE PROPER ROLE FOR THE OSMA IN MEMBER NEGOTIATIONS

Whereas, various new "alternative financing and delivery systems" such as health maintenance organizations, independent practice associations, primary care networks and preferred provider organizations are proliferating at a rapid rate; and

Whereas, most of these programs are being established by entities possessing large capital reserves, such as insurance companies, hospitals, and various for-profit corporations; and

Whereas, if this trend continues, it will become increasingly difficult for the independent private practicing physician to negotiate or compete in the marketplace, THEREFORE BE IT

RESOLVED, That the Council of the OSMA investigate methods by which the OSMA can assist its members in negotiating with alternative health financing and delivery systems and in competing in the marketplace; and be it further

RESOLVED, That a report be prepared for the 1985 Annual Meeting.

The Committee recommends adoption.

By official action, *the House adopted Substitute Resolution 19-84.*

RESOLUTION 21-84 — PAYMENT FOR PHYSICIANS' SERVICES
RESOLUTION 22-84 — INDEMNITY INSURANCE

Because of a similar nature, Resolutions 21-84 and 22-84 were combined.

The matter of Indemnity versus UCR insurance coverage is being actively assessed by the AMA. The Committee feels that it would not be advantageous to obligate the Ohio Delegation to the AMA to a fixed position prior to their participation in full discussion of the matter at the June AMA meeting.

The Committee therefore recommends rejection.

The House did not agree with the Committee's recommendation and a Substitute Resolution was introduced, which was amended on the floor of the House. Amended portions are indicated in capital letters. The substitute resolution reads as follows:

SUBSTITUTE RESOLUTION 21-84
PAYMENT FOR PHYSICIANS' SERVICES

Whereas, indemnity insurance plans

allow the doctor and patient the right to make their own arrangements for payment of fees, and

Whereas, although UCR plans are designed to be reflective of the fees in a community, they may cause animosity between patients, and

Whereas, patients should have the right to free choice of hospital and medical reimbursement plans; therefore be it

RESOLVED, that ALTHOUGH INDEMNITY HEALTH INSURANCE PLANS ARE PREFERRED, both indemnity and UCR plans SHOULD continue to be MADE available so that patients may freely choose among various reimbursement methods, INCLUDING CO-PAYMENT and DEDUCTIBLE METHODS; and be it further

RESOLVED, that patients maintain the right to assign benefits to their physicians under all health insurance plans; and be it further

RESOLVED, THAT THE AMA DELEGATION BE INSTRUCTED TO CARRY THIS RESOLUTION TO THE AMA.

By official action, *the House adopted Substitute Resolution 21-84, as amended.*

THE REPORT OF RESOLUTIONS COMMITTEE NO. 1, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

Dr. Pfahl requested permission for President-Elect Payne to preside over the House during the debate on the report of Resolutions Committee No. 2. The request was granted and Dr. Payne "assumed the chair."

Report of Resolutions Committee No. 2

Dr. Joseph Sudimack, Jr., Trumbull County, reported for Resolutions Committee No. 2, of which he was Chairman. The report is as follows:

Resolutions Committee No. 2 met in open session at 8:00 a.m. on Saturday, May 19, 1984, and heard testimony on assigned Resolutions 23 through 41 and Report A — 1984. The Committee heard spirited debate on several resolutions.

RESOLUTION 23-84 — MILITARY PHYSICIAN MEMBERS

The Committee recommends Amended Resolution 23-84 be adopted in lieu of Resolution 23-84.

AMENDED RESOLUTION 23-84 MILITARY PHYSICIAN MEMBERS

Whereas, it is desirable to have all physicians in the State as members of the Ohio State Medical Association; and

Whereas, the Second OSMA District will soon have contained within it one of the largest military medical facilities in the United States; and

Whereas, military physicians practicing within this facility will number approximately 165; and

Whereas, the shared experiences of military and civilian physicians are desired within the medical community; and

Whereas, the principal reason given for non-membership in the county and State Association is the present State dues structure for these transient military members; THEREFORE BE IT

RESOLVED, That the Council of the Ohio State Medical Association and county societies promote strategies that would encourage ACTIVE DUTY military physicians to become members of the Ohio State Medical Association.

By official action, *the House voted to amend Amended Resolution 23-84 and adopted it.* The amendment is indicated in capital letters.

RESOLUTION 24-84, CLARIFICATION OF UCR AND INDEMNITY

The Committee recommends that Resolution 24-84, which was requested to be amended by the sponsor, be rejected due to duplication in Resolution 21-84, Payment for Physicians' Services, and Resolution 22-84, Indemnity Insurance. Similar issues regarding UCR and Indemnity are under consideration by the AMA House of Delegates.

By official action, *the House rejected Resolution 24-84.*

RESOLUTION 26-84 — CPT-4 CODES FOR COMPLEX SERVICES

Resolution 26-84 reads as follows:

Whereas, Medicare and most insurance companies are using CPT-4 codes as a basis for payment of physicians' fees; and

Whereas, current CPT-4 codes are inadequate to describe some of the more complex and time consuming non-procedural physicians' services (1); and

Whereas, codes are needed for complex and unusually complex office and home visits for new and established patients, as well as for other non-procedural services; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association respectfully request the Department of Health Care Resources of the AMA to add CPT-4 codes which adequately describe more complex and time consuming non-procedural services performed by physicians.

The Committee recommends adoption.

By official action, *the House adopted Resolution 26-84.*

RESOLUTION 28-84 — FAIRNESS IN GOVERNMENT PROGRAMS

The Committee recommends Resolution 28-84 be referred to the OSMA Committee on Government Relations for study and report to the OSMA House of Delegates at its 1985 Annual Meeting. This action would negate the request to present this resolution to the AMA House of Delegates at its Annual Meeting in June, 1984.

The resolution reads as follows:

Whereas, the study of and implementation of alternate methods and/or systems of health care delivery have been greatly encouraged in recent years, especially by the federal government; and,

Whereas, certain alternate health care systems, especially the Health Maintenance Organizations (HMO), have been and are being subsidized by the federal government; and,

Whereas, many alternate health care systems are restrictive, discriminatory and arbitrary in their methods of selection of members of such plans, thus resulting in inevitable favorable bias in their statistics; THEREFORE BE IT

RESOLVED that the Ohio State Medical Association go on record as being opposed to those alternate methods of health care which are or have been federally subsidized and which accept only highly selected low risk patients and, be it further

RESOLVED that this or a similar resolution be introduced by the Ohio Delegation at the AMA House of Delegates session to be held in June, 1984 requesting that the AMA take such legal actions as may be necessary in order to assure that alternate methods of health care, including HMOs, be required to accept a proportionate share of Medicare, Medicaid, Welfare, etc. patients in essentially the same ratio as such patients exist in their health care community.

The House referred Resolution 28-84 to the OSMA Committee on Government Relations, asking for a report at the 1985 Annual Meeting.

RESOLUTION 29-84 — PATIENT INFORMATION PROGRAM
RESOLUTION 40-84 — PUBLIC EDUCATION ON THE IMPACT OF CHANGES IN THE MEDICAL CARE SYSTEM
RESOLUTION 41-84 — EDUCATING THE PUBLIC REGARDING COSTS AND QUALITY OF GOVERNMENT MEDICAL CARE PROGRAMS

The Committee considered Resolutions 29-84, 40-84, and 41-84 together and recommends the following substitute resolution:

SUBSTITUTE RESOLUTION 29-84 PATIENT AND PUBLIC INFORMATION PROGRAM

Whereas, extremely important changes in the medical care system are occurring rapidly and with increasing frequency; and

Whereas, the state and federal governments have imposed various experimental health care delivery and financing systems upon the citizens of this nation without adequate regard for access to care and quality of care; and

Whereas, the majority of our citizens have received little or no information about, and thus lack a thorough understanding of, these experimental systems; and

Whereas, a basic role of the physician is to serve as patient advocate, THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association establish as a top-priority a public education effort organized by the OSMA Department of Communications to provide information regarding the effect of social, economic and

scientific changes in the medical care system; and be it further

RESOLVED, That this resolution be forwarded to the American Medical Association for similar action on a national level.

The Committee observed that several of the programs called for in the first "RESOLVED" are already being conducted. Additional funding necessary to implement the resolution should be obtained through the normal budget process of the OSMA and the AMA.

By official action, *the House adopted Substitute Resolution 29-84.*

RESOLUTION 30-84 — URGENT CARE AND EMERGENCY MEDICAL CARE FACILITIES

The Committee noted in its deliberations that there is now in the proposed Certificate of Need legislation, House Bill 802, a clear definition of free-standing emergency facilities; therefore the Committee recommends Resolution 30-84 be referred to the OSMA Committee on State Legislation for monitoring.

The resolution reads as follows:

Whereas, the development of urgent care or "emergency medical care" facilities is increasing; and

Whereas, such facilities may help patients get quick medical care; and

Whereas, there is also a risk that patients may mistakenly think that such facilities are the equivalent of a hospital emergency room; and

Whereas, such confusion may result in delay in obtaining appropriate care; and

Whereas, there is a need to adequately inform people of the exact purpose of such facilities; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association appoint a task force to develop model legislation to accurately define urgent care or emergency medical care facilities and to require licensing of all medical institutions, other than private physicians' offices, which exist to provide urgent or emergency care to patients.

By official action, *the House referred Resolution 30-84 to the OSMA Committee on State Legislation.*

RESOLUTION 31-84 — CLEARINGHOUSE FOR INFORMATION CONCERNING MEDICALLY-RELATED COMPUTER SOFTWARE

The Committee recommends Resolution 31-84, which was requested to be amended by the sponsor, be referred to the OSMA Council for study with the idea that a central clearinghouse may have merit.

The resolution reads as follows:

Whereas, there is increasing need for current information on the use of computers in medicine, especially in terms of what software is available and its quality; and

Whereas, there is no one local or state source for the orderly distribution of such information; and

Whereas, the OSMA and its MSS are the only bodies representing all physicians and medical students in the state of Ohio; THEREFORE BE IT

RESOLVED, That the OSMA appoint a committee to study the feasibility of compiling and maintaining a current listing of available medical software; be it educational, business or research oriented; and be it further

RESOLVED, That if appropriate, this said committee review and document the content of such medical software and distribute this compiled information periodically as it sees fit.

By official action, *the House referred Resolution 31-84 to the OSMA Council.*

RESOLUTION 33-84 — LIFE-SUSTAINING THERAPY

The Committee recommends Resolution 33-84 be adopted with the following editorial change:

RESOLVED, That the Ohio State Medical Association, in cooperation with component county medical societies in Ohio, encourage hospital medical staffs that have not done so, to develop internal review procedures to be considered whenever the decision to withhold or withdraw life-sustaining therapy is being considered.

By official action, *the House adopted 33-84.*

RESOLUTION 34-84 — PHYSICIAN LIABILITY EXPOSURE IN PARTICIPATION AGREEMENTS

Resolution 34-84 reads as follows:

Whereas, physicians in Ohio are increasingly solicited for HMO, PPO, IPA, and other corporate group participating practices; and

Whereas, these contractual arrangements may have unsuspected or unusual liability exposure to physicians, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association, in consultation with Physicians Insurance Company of Ohio, immediately review the liability exposure to physicians in HMO, PPO, IPA, and other participating agreements; and be it further

RESOLVED that this information be promptly disseminated to physicians of the State of Ohio.

The Committee recommends adoption.

By official action, *the House adopted Resolution 34-84.*

RESOLUTION 35-84 — QUALITY ASSURANCE AND PEER REVIEW IMMUNITY FOR PPOs

The Committee was not in a position to separate the issues of quality of care from the economic aspects. The inability to make this delineation would complicate and confuse the legislative issue and therefore decrease the possibility of implementation of the resolution and any enactment of legislation. Therefore, the Committee recommends that Resolution 35-84 be referred to OSMA Council for further study.

RESOLVED, That quality assurance and peer review activities performed by PPOs also be granted immunity from discovery; and be it further

RESOLVED, That the Ohio State Medical Association work to enact legislation to accomplish this.

By official action, *the House referred Resolution 35-84 to the OSMA Council for further study.*

RESOLUTION 37-84 — HOSPITAL ETHICS COMMITTEES

The Committee recommends Resolution 37-84 be adopted.

The resolution reads as follows:

Whereas, the increasing complexity of medical practice is forcing physicians to confront a multitude of ethical issues; and

Whereas, the general public is becoming more knowledgeable about medical affairs and expects the best medical treatment available, possibly overruling the decision of the physician; and

Whereas, the non-medical community is, and will continue, to question the physician's right to make these often life-or-death choices; and

Whereas, the number of medical malpractice suits has risen considerably over the past several years, forcing physicians to practice defensive medicine; and

Whereas physicians may, in some instances, benefit greatly from a forum established to discuss and guide them in making ethical decisions; THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association encourage the development of individual hospital ethics committees, which should include representation from both the medical STAFF and non-medical FIELDS. ~~(legal, clergy, patient advocate) fields, to work in tandem with medical societies' ethics committees.~~

By official action, the House voted to amend Resolution 37-84 and adopted it. The amendments are indicated in capital letters and the deletions by strike-outs.

RESOLUTION 38-84 — FREE CHOICE OF PHYSICIAN

AMENDED RESOLUTION 38-84 FREE CHOICE OF PHYSICIAN

Whereas, some local hospitals have adopted employee health insurance programs which cover 100% of the hospital bill of the insured when admitted to the same facility in which they work, but only 80% at any other hospital; and

Whereas, most local primary care physicians do not admit their patients to all of the local hospitals; and

Whereas, this scheme causes many patients to seek another physician when hospitalization is required, thereby restricting free choice of physician; and

Whereas, the quality and cost of medical care can be adversely affected when the admitting physician has no previous knowledge of the patient; THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association encourage public support for health care plans which permit free choice of physician.

The Committee recommends Resolution 38-84 be adopted as amended.

By official action, *the House adopted Amended Resolution 38-84.*

REPORT A-1984 — REPORT OF THE AD HOC COMMITTEE TO REVIEW

HOUSE OF DELEGATES POLICY

The Committee recommends Report A-1984 be adopted with the amended addition of Resolution 65-80, Mental Health Coverage by Physician-Sponsored Health Care Plans.

POLICIES TO BE RETAINED — 1980 HOUSE OF DELEGATES PROCEEDINGS

7-80 Mandatory Continuing Medical Education
9-80 Funding for the Ohio State Medical Board
16-80 C.T. Scanning
30-80 Mothers Day/Annual Meeting
37-80 Participation in Organized Medicine
41-80 OSMA Dues Increase
45-80 The Physician's Role in Returning Patients to Their Jobs
47-80 Disaster Services Agency (Emergency Medical Services)
49-80 Regionalization and Categorization of Medical Services
50-80 Outpatient Physicians Service Reimbursement
51-80 Reaffirmation of Existing Policy
53-80 Medical Release Form
54-80 Certificate of Need Legislation
56-80 Confidentiality of Physician-Patient Communications
59-80 Qualifying Expert Witnesses
60-80 Labeling Generic Substitutes
65-80 Mental Health Coverage by Physician-Sponsored Health Care Plan
66-80 Establishment of a Liaison Committee for Communication and Interaction with the EPA and with State County Health Commissioners

By official action, *the House adopted Amended Report A-1984.*

RESOLUTION 32-84 — REPORT ON RESOLUTIONS FROM PRIOR YEARS

The Committee placed Resolution 32-84 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, in 1979, the House of Delegates of the Ohio State Medical Association adopted Resolution 19-79 which stated, "RESOLVED that Council appoint an Ad Hoc Committee from the OSMA Council and the House of Delegates to review past resolutions of the House of Delegates up to and including those from 1978, said committee to report to Council prior to 60 days of the next annual meeting with its recommendation as to those resolutions that should continue to be the policy of this Association and Council shall in turn submit its recommendations to the House of Delegates for its action of the opening session of the 1980 Annual Meeting; and

Whereas, the members of the House of Delegates should be given a complete report explaining the reason that the OSMA Ad Hoc Committee to Review House of Delegates Policy recommends that a resolution not be retained; THEREFORE BE IT

RESOLVED, that the Ad Hoc Committee to Review House of Delegates Policy shall include in its report an explanation of the reason(s) that it recommended that a resolution not be retained.

By consent, *the House adopted Resolution 32-84.*

RESOLUTION 36-84 — PHYSICIAN CRITICISM OF COLLEAGUES

(Identical to Resolution 39-84)

The Committee placed Resolution 36-84 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, the Ohio State Medical Association is a statewide organization of physicians; and

Whereas, two of the missions of the Ohio State Medical Association are the betterment of medical care and the maintenance of good physician inter-relationships; and

Whereas, critical comments about the care provided to a patient by another physician without full knowledge of the circumstances under which such care was provided can seriously undermine general confidence in physicians and may lead to serious and grievous professional misunderstandings; and

Whereas, critical comments about one's peers can be divisive at a time when such divisiveness cannot be afforded by the profession; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association continually encourage all physicians to make a sincere and conscientious effort to be constructive and positive in criticism of their peers.

By consent, *the House adopted Resolution 36-84.*

THE REPORT OF RESOLUTIONS COMMITTEE NO. 2, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

Dr. Payne yielded the chair to Dr. Pfahl who called up the report of Resolutions Committee No. 3.

Report of Resolutions Committee No. 3

Dr. Richard J. Nowak, Cuyahoga County, as chairman, presented the report of Resolutions Committee No. 3:

Resolutions Committee No. 3 met in open session on Saturday, May 19, 1984, and heard testimony relating to Resolutions 42-84 through 63-84, and the President's Address. The hearings were well attended and many opinions were presented on the various resolutions. The Committee wishes to thank the physicians who presented their views.

RESOLUTION 43-84 — FINANCIAL SUPPORT — HOMELESS AND CHRONICALLY MENTALLY ILL

The Committee heard testimony regarding Resolution 43-84 and recommends the following amended resolution.

AMENDED RESOLUTION 43-84 FINANCIAL SUPPORT — HOMELESS AND CHRONICALLY MENTALLY ILL

Whereas, there is a continuing increase of chronically mentally ill who are sleeping in the street without adequate care; and

Whereas, deinstitutionalization has not been effective in the management of the chronically mentally ill, and

Whereas, many of the chronically mentally ill, as a result of deinstitutionalization, are not receiving adequate medical and psychiatric treatment; THEREFORE BE IT

RESOLVED, that the OSMA should lobby state and federal legislators to provide adequate and appropriate support for the care of chronically mentally ill who are homeless.

The Committee recommends adoption.

By official action, *the House adopted Amended Resolution 43-84.*

RESOLUTION 44-84 — USER TAX ON CIGARETTES

The Committee was in favor of Resolution 44-84, as amended.

AMENDED RESOLUTION 44-84 USER TAX ON CIGARETTES

Whereas, evidence is abundant that smoking is a leading cause of lung cancer and other debilitating and often-fatal diseases, and

Whereas, there is widespread interest among health-related professional organizations and voluntary agencies, individual physicians, medical schools, and the public for prevention, control and research in cancer and other smoking-related diseases, and

Whereas, House Bill 622 calls for an increase in the Ohio cigarette tax by four cents per pack to fund cancer research and treatment but does not address broader considerations in prevention and control of cancer and other smoking-related diseases; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association support the concept of House Bill 622, and be it further

RESOLVED, that the OSMA cooperate with the sponsor(s) of House Bill 622 to add language that would provide for public education for prevention and control of ~~cancer and~~ smoking-related diseases, and be it further

RESOLVED, that when the bill incorporates these issues, members of OSMA be encouraged to contact their legislators individually to urge adoption of the bill at the earliest possible date. The Committee recommends adoption.

By official action, *the House adopted Amended Resolution 44-84,* with one minor amendment indicated.

RESOLUTION 45-84 — USER TAX ON ALCOHOL

The Committee was in favor of Resolution 45-84, as amended.

AMENDED RESOLUTION 45-84 USER TAX ON ALCOHOL

Whereas, a significant percentage of Ohio's traffic fatalities are alcohol related, and

Whereas, there is a need for increased education and research programs pertaining to the causes, detection, prevention, and treatment of alcoholism and rehabilitation of alcoholics, and

Whereas, House Bill 654 would increase by two cents per gallon the tax paid to the General Revenue Fund from spirituous liquor sales and would allocate the additional revenue for adolescent alcohol

and drug abuse treatment, and

Whereas, House Bill 654 makes no provision for programs addressing the prevention and control of alcohol-related illnesses; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association support the concept of House Bill 654, and be it further

RESOLVED, that the OSMA cooperate with the sponsor of House Bill 654 to add language that would provide for public education for prevention and control of alcohol-related illnesses, and be it further

RESOLVED, that when the bill incorporates these issues, members of OSMA be encouraged to contact their legislators individually to urge adoption of the bill at the earliest possible date.

The Committee recommends adoption.

By official action, *the House adopted Amended Resolution 45-84.*

RESOLUTION 46-84 — MANDATORY USE OF PROTECTIVE HELMETS FOR MOTORCYCLISTS

The Committee was in favor of Resolution 46-84, as amended.

AMENDED RESOLUTION 46-84 MANDATORY USE OF PROTECTIVE HELMETS FOR MOTORCYCLISTS

Whereas, studies have shown conclusively that the use of protective helmets by motorcycle operators and passengers is a significant factor in the prevention of serious injury or death due to accidents, and

Whereas, the cost resulting from such accidents, in terms of human suffering as well as medical and rehabilitative expense, is unconscionable in light of the fact that effective protective devices are readily available, and

Whereas, the so-called right of the individual to free choice in such matters must be weighed against the rights of others who may be affected by his action, and against the rights of society as a whole; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association lobby for enforceable legislation that mandates the use of protective headgear for all motorcycle AND MOPED operators and passengers in Ohio.

The Committee recommends adoption.

By official action, *the House adopted Amended Resolution 46-84.*

RESOLUTION 47-84 — THE USE OF SEAT RESTRAINTS FOR AUTOMOBILES IN THE STATE OF OHIO

The Committee was in favor of Resolution 47-84 with a minor editorial change.

AMENDED RESOLUTION 47-84 THE USE OF SEAT RESTRAINTS FOR AUTOMOBILES IN THE STATE OF OHIO

Whereas, of the 1,794 automobile drivers and passengers killed on Ohio highways in 1982 and 1983, 1,670 (93%) were not wearing seat belts, and

Whereas, the mental and emotional anguish and the financial burdens incurred by the families of the victims are, irreversible, and

Whereas, statistics prove that the use of seat belts dramatically reduces the incidence of serious injury and death, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association lobby for enforceable legislation mandating the use of seat belts during automobile travel in the State of Ohio.

The Committee recommends adoption.

By official action, *the House adopted Resolution 47-84.*

RESOLUTION 48-84 — RECOGNITION OF THE 150TH ANNIVERSARY OF THE OHIO STATE UNIVERSITY COLLEGE OF MEDICINE

The Committee was in favor of Resolution 48-84 with minor editorial changes.

AMENDED RESOLUTION 48-84 RECOGNITION OF THE 150TH ANNIVERSARY OF THE OHIO STATE UNIVERSITY COLLEGE OF MEDICINE

Whereas, the College of Medicine which is now a part of The Ohio State University was established by legislative act of the Ohio General Assembly on March 3, 1834, and

Whereas, the College of Medicine has carried out its missions of providing patient care, educating physicians, conducting research and providing service to the community and the State of Ohio in an exemplary manner for 150 years; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association joins in celebrating the Ohio State University College of Medicine's Sesquicentennial, and recognizes the signal contributions of the college of medicine toward the achievement of excellence in medical care for the citizens of the State of Ohio.

The Committee recommends adoption.

By official action, *the House adopted Resolution 48-84.*

RESOLUTION 49-84 — PREFERENCE FOR HOSPITAL DELIVERY OVER HOME BIRTHS

The Committee heard testimony relative to the greater risks of home deliveries. However, the Committee deleted the last proposed resolve because the Committee felt that it was inappropriate to inject the OSMA into the marketing decisions involving birthing environments in hospitals. Therefore we submit the following amended resolution.

AMENDED RESOLUTION 49-84 PREFERENCE FOR HOSPITAL DELIVERY OVER HOME BIRTHS

Whereas, an increasing number of parents are choosing family-oriented home delivery as an alternative to conventional hospital delivery, and

Whereas, there is risk to both mother and child inherent in every phase of labor and delivery and in the immediate postpartum period, and

Whereas, statistics have repeatedly shown that the incidence of preventable perinatal and post-natal morbidity and mortality is significantly higher in out-of-hospital births, even among the low risk population and with optimum prenatal care, and

Whereas, it is recognized that parents have a right to experience to the fullest extent the birth of their child, and it is equally true that the child has a right to be born as safely, and in the most supportive environment as possible, and

Whereas, with the development of birthing centers within the hospital, physicians and hospitals are responding to patients' wishes for a closer family involvement in the birth process, while assuring the full support of the hospital's facilities should they be needed; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association encourage its members to educate their patients about the increased risks of home delivery compared to hospital delivery, AND BE IT FURTHER

RESOLVED, THAT THE OSMA ENCOURAGE ITS MEMBERS TO ASSIST THEIR HOSPITALS IN CREATING MORE COMFORTABLE BIRTH ENVIRONMENTS FOR PATIENTS AND THEIR FAMILIES.

The Committee recommends adoption of Amended Resolution 49-84, and I so move.

By official action, *the House amended and adopted Amended Resolution 49-84.* The amendment is indicated in capital letters.

RESOLUTION 52-84 — MEDICAL SCHOOL ENROLLMENT

The resolution provoked considerable discussion of the complexity of this problem. The Committee believes that it will continue to be a problem. The Committee deliberated at great length and concluded that the concept of reduction of students is premature until further data is available. Therefore, the Committee moves that this substitute resolution be adopted.

SUBSTITUTE RESOLUTION 52-84 MEDICAL SCHOOL ENROLLMENT

Whereas, there appears to be great concern regarding the number of new physicians setting up practice in Ohio, and

Whereas, there are conflicting opinions regarding the needed cuts in medical school enrollment in Ohio, and

Whereas there is also concern about related issues, such as FMG's and net influx of new physicians into Ohio, and

Whereas, the OSMA has a vested interest and responsibility to be knowledgeable about issues such as these, and

Whereas, the OSMA-Medical Student Section supports the concept of altering of medical school enrollment in Ohio, THEREFORE BE IT

RESOLVED, that the OSMA conduct a review, investigate and prepare a report on all pertinent issues regarding medical school enrollment in Ohio, and be it further

RESOLVED, that this OSMA review include a policy statement regarding medical school enrollment specifically addressing mechanisms of change if indicated.

The Committee recommends adoption.

By official action, *the House voted to refer Substitute Resolution 52-84 to the OSMA Council, asking a study and a report be made to the 1985 House of Delegates meeting.*

RESOLUTION 54-84 — COOPERATIVE COALITION COMMITTEE

The Committee recognizes that the OSMA already has a liaison committee with the Ohio Nurses Association. The Committee feels, however, that it is important to include the Ohio Hospital Association in the coalition effort.

The Committee recommends adoption.

The resolution reads as follows:

Whereas, there are multiple and varied pressures being exerted upon the total Health Care Delivery System, and

Whereas, the key components of this system, Physicians, Nurses and Hospitals, are being pitted against each other, and

Whereas, controversies, competition, differences of philosophies, turf battles and in general, divisive forces are becoming operative within each of the components, and

Whereas, the recipients of Health Care are being caught in the middle and are likely to be the biggest losers; THEREFORE BE IT

RESOLVED, that a positive effort be made to realign Physicians, Nurses and Hospitals into a more cooperative coalition for the purpose of delivering the best medical care to those who need it and in the most efficient manner. ~~and be it further --RESOLVED, that Ohio's Physicians in the form of the O.S.M.A. initiate this effort by inviting the Ohio Nurses Association and Ohio Hospital Association to form a task force for this purpose.~~

By official action, *the House amended Resolution 54-84, by deleting the last "RESOLVED" and adopted it.*

RESOLUTION 55-84 — ACLS AND ATLS COURSES FOR PHYSICIANS

After deliberation, the Committee felt that a change in the second resolve would be necessary to avoid dictating the specific content of residency programs. The Committee, however, feels that the courses should be made available in all residency programs.

AMENDED RESOLUTION 55-84 ACLS AND ATLS COURSES FOR PHYSICIANS

RESOLVED, that the Ohio State Medical Association strongly urge that physicians PRIMARILY responsible for the care of multiple systems trauma be certified in Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS) and be it further

RESOLVED, that Ohio State Medical Association urges that certification in Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS) be INCLUDED ~~AVAILABLE~~ in all GENERAL SURGICAL AND EMERGENCY MEDICAL residency programs AND AVAILABLE IN ALL OTHER RESIDENCY PROGRAMS.

The Committee recommends adoption.

By official action, *the House amended Amended Resolution 55-84 and adopted it.* The amended portions are denoted by capital letters for the additions and strike-outs for the deletions.

RESOLUTION 57-84 — VIOLENCE IN MOVIES AND TELEVISION

Since other organizations are already involved in attempts to reduce violence in movies and television, the Committee offers an editorial change of one word.

AMENDED RESOLUTION 57-84 VIOLENCE IN MOVIES AND TELEVISION

Whereas, in 1976, the American Medical Association in recognition of the potential damage to society as a result of the display of violence in TV programs adopted Resolution 38 and Board of Trustees Report N, and

Whereas, in 1982, the American Medical Association reaffirmed the policy adopted in 1976 and directed the Board of Trustees of the AMA to reinstitute an action program designed to increase awareness of physicians and patients that television violence is a risk factor threatening the health of young Americans, and

Whereas, despite the efforts of the American Medical Association and other professional associations, the portrayal of violence in television programs and movies continues to be a major risk factor; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association join the American Medical Association, the American Psychiatric Association, the American Academy of Pediatrics and other interested organizations to investigate new and innovative methods to reduce the amount of violence that is portrayed in television programs and movies.

The Committee recommends adoption.

By official action, *the House adopted Amended Resolution 57-84.*

RESOLUTION 60-84 — PRESCRIBING PRACTICES

The Committee studied the legal implications of using a signed prescription as an item of barter and felt that the resolution should be amended as follows:

AMENDED RESOLUTION 60-84 PRESCRIBING PRACTICES

Whereas, the Ohio First District Court of Appeals recently upheld a lower court ruling in dismissing 17 counts of drug trafficking against an Ohio physician accused of trading drug prescriptions for sexual favors; and

Whereas, the appellate judges held that writing a prescription for whatever reason did not constitute a sale of a drug; and

Whereas, the judges determined that the problem is with current Ohio law which does not address whether the transfer of a prescription form is the same legally as the physical delivery of drugs and would therefore constitute the felony of drug trafficking; and

Whereas, a prescription is written direction for a therapeutic or corrective agent and prescriptive authority is entrusted to a limited number of health care professions due to the high potential for misuse and/or abuse of controlled substances; and

Whereas, the Ohio State Medical Association has continuing interest in promoting proper prescribing practices by its members and has in the past encouraged this by educational, regulatory, and legislative means; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association Legal Department investigate the First District Court of Appeals ruling in dismissing 17 counts of drug trafficking against an Ohio physician and determine whether or not a revision in Ohio law is necessary, and report findings to the Committee on State Legislation for possible legislative action.

The Committee recommends adoption of Amended Resolution 60-84.

By official action, *the House referred Amended Resolution 60-84 to the OSMA Council.*

RESOLUTION 50-84 — SUPERVISION OF PHYSICIAN ASSISTANT RESOLUTION 63-84 — PHYSICIAN ASSISTANT

The Committee considered these two resolutions together because they concern both sides of a complex issue. After considerable testimony, heated at times, and after prolonged deliberation, the Committee recommends rejection of Resolution 63-84. It was rejected by the House.

The Committee recommends the following:

SUBSTITUTE RESOLUTION 50-84 SUPERVISION OF PHYSICIAN ASSISTANTS

Whereas, for more than five years, the Ohio State Medical Association has actively opposed state legislation seeking institutional employment of physicians assistants, and

Whereas, in addition to the factors on which OSMA originally based its position, the number of physicians has increased dramatically in recent years to the point where a physician "surplus" is of general concern, and

Whereas, physician assistants, by training and by current law, cannot independently provide the full spectrum of medical care to patients, and

Whereas, the employment of physician assistants by licensed physicians was designed to provide supervised primary medical care in times and places of inadequate physician manpower; therefore be it

RESOLVED, that the Ohio State Medical Association reaffirm its present policy of opposition to any legislative effort seeking institutional employment of physician assistants.

The Committee moves adoption of Substitute Resolution 50-84.

By official action, *the House adopted Substitute Resolution 50-84.*

PRESIDENT'S ADDRESS

President Pfahl discussed several "highs" and also some "lows" during the past year. He cited complexities of the Governor's Commission on Health Care Costs under the watchful eyes of Dr. Ross Irons and OSMA staff.

He cautioned about the unparalleled changes recommended by state government in the way health care is delivered in Ohio and the way you will practice in the future. He urged that OSMA members be actively involved in this process by maintaining contact with their policymakers in Columbus and Washington.

Dr. Pfahl cited OSMA's involvement in the successful fight in Washington against mandatory assignment of Medicare inpatient benefits — but emphasized that this is only the first skirmish in the upcoming war over next year's planned Medicare revisions. He emphasized that only through our collective efforts can we partially impact on the forces of legislative change pressuring the Medicare system.

Dr. Pfahl called for increased AMA membership, support of the fee freeze, continued programs of medical care for the unemployed, strong financial support for OMERF, and strong support for our active, effective Auxiliary.

Among the "highs," Dr. Pfahl announced a new OSMA program to stimulate marketing and communication skills entitled **The Extra Mile.**

Dr. Pfahl's final statement, borrowed from his father-in-law should be remembered by all.

"You take good care of your patients, and they will take good care of you, or to phrase it another way, it is more blessed to give than to receive."

In conclusion, this young, dynamic President moved OSMA ahead on all fronts. We must adopt his energy and enthusiasm in order to meet numerous challenges and hurdles on the road to the future.

The House accepted the report by acclamation and it was filed.

RESOLUTION 42-84 — RESIDENT SECTION — OSMA

The Committee placed Resolution 42-84 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, the AMA and OSMA have both established a student section, and

Whereas, the AMA has recently developed a resident's section, and

Whereas, studies have shown that a greater percentage of residents remain in the state where they train, and

Whereas, it is important to the OSMA and organized medicine that these new physicians become involved and active early in their careers, then THEREFORE BE IT

RESOLVED, that the OSMA President appoint a committee to investigate the interest of resident physicians (physicians in training) in having a Resident's Section and be it further

RESOLVED, that if the interest exists that the committee prepare a resolution for the 1985 Annual Meeting authorizing the establishment of an OSMA Resident's Section.

By consent, *the House adopted Resolution 42-84.*

RESOLUTION 51-84 — FUNDING FOR THE OHIO STATE MEDICAL BOARD

The Committee placed Resolution 51-84 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, Section 4731.281 of the Ohio Revised Code requires that a physician pay a fee of one hundred dollars at the time of each biennial registration, and

Whereas, the Ohio State Medical Board is dependent upon the Ohio General Assembly for its funding, and

Whereas, The Ohio State Medical Board could improve its effectiveness if it had additional funds for an adequate number of investigators and administrative staff; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association reaffirm its present policy (Resolution 9-80), and be it further

RESOLVED, that the OSMA encourage its membership to contact their legislators individually to urge additional funding for an adequate number of investigators and administrative staff for the Ohio State Medical Board.

By consent, *the House adopted Resolution 51-84.*

RESOLUTION 53-84 — APPRECIATION OF OSMA SUPPORT

The Committee placed Resolution 53-84 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, the Ohio State Medical Association membership has offered constant support to the Medical Student Section in the past, and continues to do so presently; and

Whereas, this support includes guidance and leadership in our efforts as well as financial subsidies for our activities and required travel; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association-Medical Student Section hereby extend its thanks and gratitude to the members of the Ohio State Medical Association for their continued concern and generous support.

By consent, *the House adopted Resolution 53-84.*

RESOLUTION 56-84 — INAPPROPRIATE SALE OF FIREWORKS

The Committee placed Resolution 56-84 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, each year adults and children are needlessly injured as a result of the inappropriate use of fireworks, and

Whereas, current law in Ohio permits prospective purchasers to sign a form stating they are wholesale purchasers, and

Whereas, there is currently legislation introduced in the Ohio General Assembly pertaining to the sale of fireworks; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association support the passage of legislation to amend Ohio law by restricting the sale of fireworks in Ohio to sales for direct shipment out of state or for a bona fide public display for which the purchasers have obtained a permit signed by the Fire Chief of a municipality or the County Sheriff in an unincorporated area.

By consent, *the House adopted Resolution 56-84.*

RESOLUTION 58-84 — PUBLIC PURCHASE AND CONSUMPTION OF ALCOHOLIC BEVERAGES

The Committee placed Resolution 58-84 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, in 1981 approximately 25,000 people died from alcohol related traffic accidents, and

Whereas, although drivers under the age of 21 comprise 10% of all licensed drivers, 23.6% of all alcohol related fatalities involved drivers in this age group, and

Whereas, 20% of all injuries arising from drunk driving are to teenagers, and

Whereas, the insurance industry estimates that teenage drunk driving costs the United States approximately six billion dollars per year, and

Whereas, the State of Michigan, in the first year after raising the drinking age to 21, experienced a 31% reduction in alcohol related accidents in the affected age range; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association urge the Ohio General Assembly to enact legislation to raise to age 21, the age when a person may publicly purchase or publicly consume alcoholic beverages.

By consent, *the House adopted Resolution 58-84.*

RESOLUTION 61-84 — ENHANCED 911 TELEPHONE SYSTEM

The Committee placed Resolution 61-84 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, the experience of public safety officials and other emergency service providers in Ohio indicates that people generally do not know the proper telephone number to call to obtain police, fire, or emergency medical assistance; and

Whereas, travelers and persons in unfamiliar neighborhoods do not know what jurisdiction they are in and, therefore, are unaware of which governmental agency is responsible for providing assistance to the area from which they are calling; and

Whereas, the installation of an Enhanced 911 telephone system will provide one common number to call to receive immediate accurate public safety assistance and will be answered immediately and the appropriate agency dispatched as a result of dialing 9-1-1; and

continued on page 740

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As with other nonsteroidal anti-inflammatory drugs, borderline elevations of liver tests may occur in up to 15% of patients. These abnormalities may progress, may remain essentially unchanged, or may be transient with continued therapy. Meaningful elevations of SGPT or SGOT (AST) occurred in controlled clinical trials in less than 1% of patients. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with ibuprofen as with other nonsteroidal anti-inflammatory drugs. If liver disease develops or if systemic manifestations occur (e.g. eosinophilia, rash, etc.), *Motrin* should be discontinued.
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Incidence Greater than 1% (but less than 3%)—Probable Causal Relationship
Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).
Incidence less than 1%—Probable Causal Relationship**
Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting; anaphylaxis; bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.
Incidence less than 1%—Causal Relationship Unknown**
Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmias (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis; **Renal:** Renal papillary necrosis.
*Reactions occurring in 3% to 9% of patients treated with *Motrin.* (Those reactions occurring in less than 3% of the patients are unmarked.)
**Reactions are classified under *"Probable Causal Relationship (PCR)"* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.
Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine so alkaline diuresis may be beneficial.
Dosage and Administration: Rheumatoid arthritis and osteoarthritis. Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary.
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J-4791 August, 1984

Proceedings of the House

continued

Whereas, the Enhanced 911 telephone system will markedly improve the ability of the community to save lives and lessen the degree of injury of many of our citizens with medical emergencies in Ohio; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association support the introduction of appropriate legislation that would make Enhanced 911 a reality for the citizens of Ohio.

By consent, *the House adopted Resolution 61-84.*

RESOLUTION 59-84 — RECOGNITION OF VALOR — MEDICAL RESCUE TEAM

The Committee placed Resolution 59-84 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, the Lake Erie Island area of the State of Ohio is medically underserved, particularly during the winter months when boat transportation to the mainland is not available, and

Whereas, members of a volunteer medical rescue team were drowned between South Bass Island and Kelleys Island on the night of December 9, 1983 when their airplane crashed in heavy fog, and

Whereas, these men risked and ultimately lost their lives in an effort to aid a patient in need of medical attention, exemplifying the finest intentions of the Oath of Hippocrates; THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association hereby recognizes the valor, heroism, human compassion and selflessness of:

Robert Rigoni, Pilot
Bruce Mettler, Paramedic
Duane Dress, Township Trustee
Michael Sweeney, Police Dispatcher

By consent, *the House adopted Resolution 59-84.*

RESOLUTION 62-84 — LAKE ERIE VALOR COMMENDATION

The Committee placed Resolution 62-84 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, the Ottawa County Medical Society wishes to recognize the supreme sacrifice to their fellow man above and beyond the call of duty, the Ottawa County Medical Society wishes to acknowledge and have the State Society acknowledge the four volunteers who died in an air crash on Lake Erie December 9, 1983. These men were Bruce Mettler, Robert Rigoni, Michael Sweeney and Duane Dress. They were flying to the aid of a heart attack victim on Kelleys Island when their plane went down in the fog; THEREFORE BE IT

RESOLVED, that the Ottawa County Medical Society and Ohio State Medical Association commend these men for their valor and dedication to their fellow men and regret their loss.

By consent, *the House voted to adopt Resolution 62-84.*

THE REPORT OF RESOLUTIONS COMMITTEE NO. 3, AS A WHOLE, AS

AMENDED, WAS APPROVED BY THE HOUSE.

INAUGURAL CEREMONY

Dr. Oscar W. Clarke escorted Mrs. Payne and members of the Payne family to the rostrum.

Dr. Ford administered the Presidential Oath of Office to Dr. Payne. Dr. Payne introduced the members of his family to the House.

Dr. Pfahl then presented to Dr. Payne the official gavel and the President's Medallion.

The Payne family was then seated.

Dr. James Hart escorted Mrs. Pfahl to the podium.

Dr. Payne presented to Dr. Pfahl, the past president's pin, the president's plaque, a replica of the president's medallion to Mrs. Pfahl and a replica of the president's medallion to Dr. Pfahl.

Dr. Payne then addressed the House as the new OSMA President.

There being no further business, the House of Delegates adjourned, sine die.

ATTEST: Hart F. Page, CAE
Executive Director
Carol C. Maddy
Assistant Secretary
House of Delegates

County Society Update

BUTLER: Jack S. Sizer, MD, President, 2403 Central Ave., Middletown 45042; Barry A. Robertson, MD, Secretary-Treasurer, 701 N. University Blvd., Middletown 45042.

COSHOCTON: Linda Magness, M.D., Secretary-Treasurer, 1415 Orange St., Coshocton 43812.

CUYAHOGA: Henry G. Krueger, MD, President, 20997 Lorain Rd., Cleveland 44126; Wilma F. Bergfeld, MD, Secretary-Treasurer, Cleveland Clinic, 9500 Euclid Ave., Cleveland 44106.

FAIRFIELD: Jane E. Patterson, Executive Secretary, c/o David H. Sheidler, MD, 1500 E. Main St., Lancaster 43130.

FAYETTE: Robert A. Heiny, M.D., Secretary-Treasurer, P.O. Box 457, 616 Willard St., Washington C.H. 43160.

FRANKLIN: William T. Paul, MD, President, 1300 Dublin Rd., Columbus 43215; Owen E. Johnson, MD, Secretary-Treasurer, 3545 Olentangy River Rd., Columbus 43214.

HAMILTON: Thomas R. Werner, MD, President, 58-60 E. Hollister St., Cincinnati 45219; Ann Ghory, MD, Secretary, 1430 E. McMillan St., Cincinnati 45206.

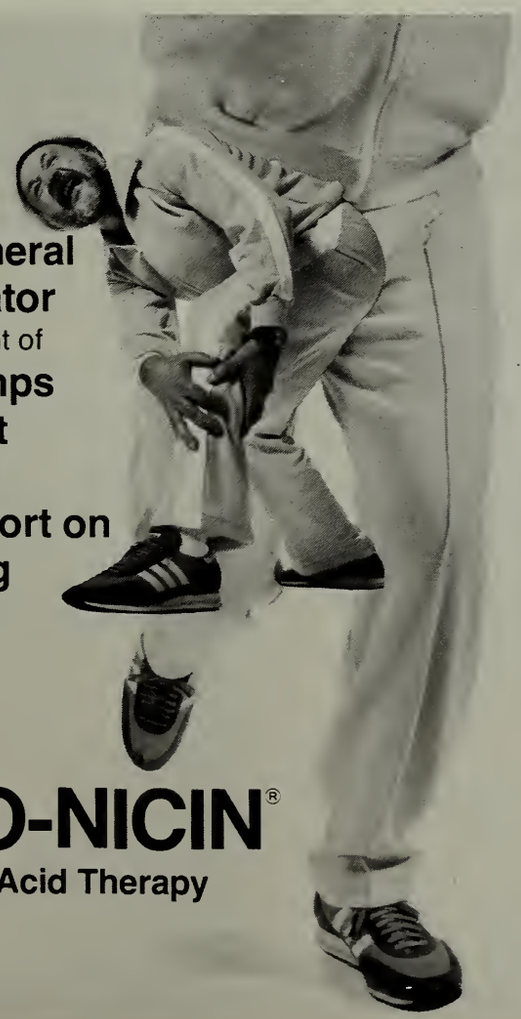
MARION: James S. Hering, MD, President, 1136 Independence Ave., Marion 43302; Ronald A. Landefeld, MD, Secretary-Treasurer, 170 Fairfax Ave., Marion 43302.

MIAMI: Peter E. Nims, MD, President, 20 South Lane, Troy 45373; Donald P. Luna, MD, Secretary, Piqua Memorial Medical Center, 624 Park Ave., Piqua 45356.

OTTAWA: Barry R. Cover, MD, President, 118 E. Perry St., Port Clinton 43452; Sharad G. Shinde, MD, Secretary-Treasurer, 130 Jefferson, Suite 3-A, Port Clinton 43452.

TUSCARAWAS: Doris Ferguson, Executive Secretary, c/o Union Hospital, 659 Boulevard, Dover 44622.

UNION: Malcolm MacIvor, MD, President, 110 N. Court St., Marysville 43040; Walter Burt, MD, Secretary-Treasurer, 31 E. State St., Milford Center 43045.



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Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

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Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
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Riboflavin (B-2) .....2 mg.
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Obituaries

SELIM JAN BLAZEWICZ, MD, Pomeroy; Ohio State University College of Medicine, 1943; age 67; died July 20, 1984; member OSMA and AMA.

RODERICK BRYCE, MD, Philadelphia, Pennsylvania; Meharry Medical College School of Medicine, Nashville, Tennessee, 1916; age 94; died June 21, 1984; member OSMA and AMA.

LEWIS E. CARROLL, MD, Mt. Vernon; Faculte de Medecine et de Pharmacie Universite libra de Bruxelles, Belgium, 1967; age 51; died June 17, 1984; member OSMA.

AUSTIN A. COULSON, MD, McConnelsville; Ohio State University College of Medicine, 1938; age 73; died July 9, 1984; member OSMA and AMA.

KURT GLAZE, MD, Copley; Southern Illinois University School of Medicine, Springfield, Illinois, 1977; age 36; died July 24, 1984; member AMA.

BERNARD KARWOWSKI, MD, Kettering; St. Louis University School of Medicine, St. Louis, Missouri, 1926; age 84; died July 22, 1984; member OSMA and AMA.

BERNARD R. LAUER, MD, Waldo; Ohio State University College of Medicine, 1937; age 72; died July 26, 1984.

RAYMOND S. LORD, MD, Mt. Vernon; Case Western Reserve University School of Medicine, 1936; age 73; died June 22, 1984; member OSMA and AMA.

ROY M. MEREDITH, MD, Marietta; Ohio State University College of Medicine, 1930; age 77; died June 24, 1984; member OSMA and AMA.

ARTHUR H. THAYER, MD, Cincinnati; University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania, 1952; age 60; died July 6, 1984; member OSMA and AMA.

NORMAN WETZEL, MD, Cleveland; Case Western Reserve University School of Medicine, 1921; age 87; died July 28, 1984; member OSMA and AMA.

Continuing Medical Education

October

HEALTH SYSTEMS MANAGEMENT EXECUTIVE EDUCATION: October 1, October 22, November 16, December 4, 1984, February 1, February 27, March 13 and April 15, 1985; Crawford Hall, Case Western Reserve University, Cleveland; 6 credit hours per session. Contact: Barbara J. Przybylski, Sears Library Building, CWRV, Cleveland 44106, phone: 216-368-2143.

THE FAMILY OF THE '80s — UPDATE 1984: October 11; Holiday Inn, I-75 & St. Rte. 55, Troy; sponsor: Dettmer Hospital, Cosponsor: Wright State University; 6 credit hours; fee: $60, $30 for students or physicians-in-training. Contact: Gerard F. Wolf, M.D., 145 Sunset Drive, Piqua 45356, phone: 513-773-8323.

November

CONTEMPORARY FACIAL RECONSTRUCTION SURGERY: November 8-11; Rhodes Auditorium, Ohio State University Medical Center, Columbus; 27.5 credit hours; fee: $525 A.A.F.P.R.S. members, $600 non-members, $300 residents. Contact: Jon Hollett, Director, Center for Continuing Medical Education, The Ohio State University, 320 West Tenth Avenue, Columbus 43210, phone: 614-422-4985.

DIAGNOSTIC AND THERAPEUTIC ADVANCES IN PULMONARY MEDICINE: November 16-17; Stouffer's Inn on the Square, Cleveland; sponsor: CWRV School of Medicine, 9 credit hours. Contact: Jean Kerr, 2119 Abington Road, Cleveland 44106, phone: 216-368-2408.

LEARNING DISABILITIES: November 28; Bunts Auditorium, Cleveland Clinic; sponsor: The Cleveland Clinic Educational Foundation; 6 credit hours; fee: $75, $50 for students or physicians-in-training. Contact: Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio, 1-800-762-8173.

PERSPECTIVES IN OPHTHALMOLOGY: November 30 and December 1; Bunts Auditorium, Cleveland Clinic, Cleveland, Ohio; 12 credit hours; fee: $200, $150 for physicians-in-training. Contact: Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

December

FOURTH ANNUAL POSTGRADUATE COURSE/ADMINISTRATIVE PSYCHIATRY: December 3-7; Marriott Hotel, Dayton; sponsor: Wright State University School of Medicine, Department of Psychiatry; 35 credit hours; fee: $350. Contact: Paul Rodenhauser, M.D., Wright State University School of Medicine, P.O. Box 927, Dayton 45401, phone: 513-276-5233.

AMBULATORY ELECTROCARDIOGRAPHY: December 5; Bunts Auditorium Cleveland Clinic; sponsor: The Cleveland Clinic Educational Foundation; 6 credit hours; fee: $75, $50 physicians-in-training. Contact: Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

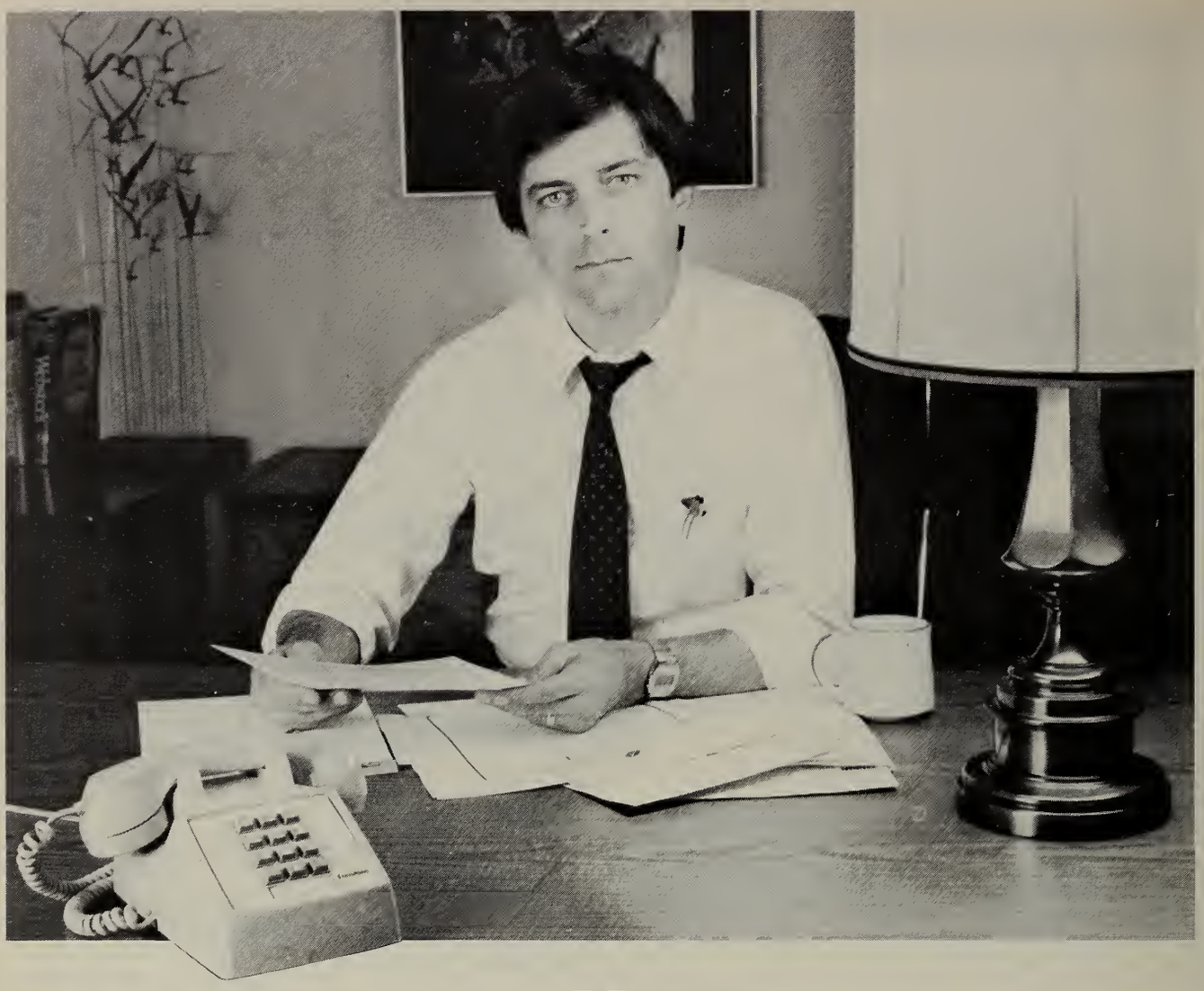
INTRODUCTION TO MEDICAL DECISION MAKING: December 7, Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 6 credit hours. Contact: Center for CME, The Cleveland Clinic, Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll free in Ohio 1-800-762-8172; Outside Ohio 1-800-762-8173.

January

SUPER EMG V: January 18-27, 1985; Montego Bay, Jamaica; sponsor: Department of Physical Medicine, College of Medicine, The Ohio State University; 42 credit hours. Contact: Jon Hollett, Director, Center for Continuing Medical Education, The Ohio State University, A352 Starling-Loving Hall, 320 West Tenth Avenue, Columbus 43210, phone: 614-422-4985.

EENT SEMINAR: January 19-26, 1985, Montego Bay, Jamaica; sponsor: Department of Otolaryngology and Department of Ophthalmology, College of Medicine, The Ohio State University; 24 credit hours. Contact: Jon Hollett, Director, Center for Continuing Medical Education, The Ohio State University, A352 Starling-Loving Hall, 320 West Tenth Avenue, Columbus 43210, phone: 614-422-4985.

1985 CONTINUING MEDICAL EDUCATION PEDIATRIC UPDATE: January 21-25; St. Croix, Virgin Islands; sponsor: Children's Hospital, Columbus; cosponsor: Ohio State University; 18 credit hours. Contact: Becky Martin, Education Department, 700 Children's Drive, Columbus 43205, phone: 614/461-2914.



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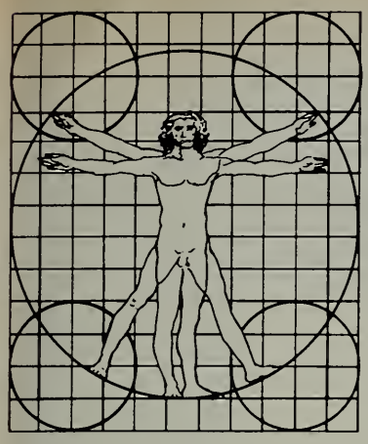
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CLINICAL & SCIENTIFIC

ADVERSE SYSTEMIC REACTIONS OF OCULAR DROPS

Richard G. Orlando, MD

The systemic side effects of eyedrops are reviewed. Systemic absorption can cause serious cardiovascular, pulmonary, gastrointestinal, and central nervous system dysfunction. An increased knowledge of eyedrop related reactions is essential to the primary care physician because of the common and widespread use of eye medication.

SINCE 1956, SEVERAL REPORTS have described serious systemic side effects with the use of ophthalmic medications. Most reports have been in the ophthalmologic literature and for this reason, the non-ophthalmologist may not consider systemic absorption of eyedrops as a cause of disease.

Because of the large number of patients on eyedrops, the family physicians and internists must develop a greater awareness of complications due to ocular drops. This paper will review the common systemic side effects associated with ophthalmic medications.

Systemic absorption of topical eyedrops occurs through the conjunctival capillaries. If allowed to pass through the lacrimal system, further amounts are absorbed in the nasal and oral mucosa and the gastrointestinal tract. Digital pressure on the nasal canthus occludes the lacrimal puncta and prevents passage into the lacrimal system. Hyperemia of the conjuctival mucosa enhances absorption.

Ocular drops are more readily taken up than ointment via the capillary network. Likewise, ointment does not pass through the lacrimal system and thus less systemic side effects occur with ophthalmic ointments.

Mydriatic and Cycloplegics

Phenylephrine, a synthetic sympathomimetic agent, is used principally as a mydriatic. Side effects from topical instillation are uncommon but usually affect the cardiovascular system. Significant hypertensive reactions have occurred following administration of phenylephrine[1] and in one case, led to a subarachnoid hemorrhage.[2] Diabetics are especially prone to the hypertensive episodes.[3] There are cases of coronary artery spasm, angina, and myocardial infarction after the use of topical phenylephrine drops. It is essential to use the drug with caution in anyone with a history of cardiovascular disease.

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Submitted: November 23, 1983

Atropine causes prolonged pupillary dilation and paralysis of accommodation. It is particularly useful as an aid in the refraction of children and to prevent formation of posterior synechiae in anterior uveitis. Common side effects include dryness, flushing of the skin, fever, and thirst. More severe reactions affect the central nervous system and may appear minutes to hours after the use of the drops. The clinical picture is similar in affected individuals and begins with ataxia so severe that the patient may be unable to sit or stand. This is followed by dysarthria, confusion, hallucinations, coma, and convulsions.[4] Children are very susceptible to atropine toxicity and if not recognized, it can lead to death.[5]

Cyclopentolote produces rapid mydriasis and cycloplegia upon topical instillation. Its duration of action is short (three to 24 hours) but transient neurotoxic reactions are occasionally observed.[6,7] The elderly and children are especially vulnerable. Affected patients exhibit incoherence, disorientation, slurred speech and visual hallucinations. These symptoms may persist for several hours.

Scopolamine closely resembles atropine in action, although its effects are of shorter duration. Reactions are similar to atropine, with dryness and flushed skin very common. There is an idiosyncratic reaction of acute psychosis associated with the use of scopolamine. Patients have altered levels of consciousness, with periods of excitation, confusion and hallucinations.[8] These symptoms may last for several hours and disappear spontaneously.

Tropicamide has a rapid onset of action with a very short duration of action. Systemic side effects are rare, although there are reports of pallor, cyanosis and respiratory arrest.

Antiglaucoma Medications

One of the most commonly used medications, pilocarpine, increases the facility of aqueous outflow and thus lowers intraocular pressure. This drug has a direct-acting effect on post ganglionic parasympathetic fibers and its side effects are due to muscarinic poisoning. Symptoms include nausea, vomiting, diarrhea, sweating, salivation, and respiratory distress.[9] Cardiac arrhythmias occasionally occur, as do CNS symptoms of confusion. These symptoms usually cease within 24 hours of treatment, but if life threatening, can be antagonized with atropine.

Echothiopate iodide is a long acting cholinesterase inhibitor and enhances the effect of acetylcholine in the iris and ciliary body. This causes miosis and increases the aqueous outflow facility, thus lowering intraocular pressure. Systemic cholinergic stimulation may cause salivation, nausea, emesis, and diarrhea.[10] Cardiac arrest and bronchospasm have occurred. Symptoms are often delayed days to weeks after instillation of ther-



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apy, thus making it difficult to identify the drug as the cause of illness. Antidote for acute toxicity is intravenous atropine and prolidoxime chloride.

Timolol maleate is a beta blocker used in the treatment of glaucoma that reduces pressure very effectively, even though its exact mechanism of action is unknown. Its adverse effects are due to beta blockade and can be quite serious. Cardiovascular side effects include palpitations, hypotension, syncope, and bradycardia.[11] Congestive heart failure has also occurred. Intrinsic asthma can be triggered and can lead to life-threatening bronchospasm.[12] Other common side effects include fatigue, lethargy, memory loss, depression and impotence. It is prudent for the prescribing physician to carefully monitor patients when starting this drug.

Topical epinephrine is used in combination with other anti-glaucoma drugs to control the intra-ocular pressure. This drug should be used with caution in patients with cardiovascular disease. Cardiac extrasystoles are very common (8%)[13] while the incidence of palpitations, hypertension, and tachycardia is relatively low.

Antibiotics

Chloromphemical is a very effective broad spectrum antibiotic and is used in treating conjunctival and corneal infections. Bone marrow hypoplasia is a very rare but possible side effect.[14] It should be suspected in patients on long-term chloromphemical therapy, with hematologic abnormalities. Cessation of the drops will usually reverse the bone marrow abnormality.

Topical Corticosteroids

Ocular steroid drops are used to treat anterior uveitis, scleritis, and in post-operative patients. Plasma cortisol levels may be reduced with their use.[14] This can lead to adrenal gland suppression. It is possible that diabetes and GI ulcers could be worsened with topical steroid therapy.

An awareness of the serious systemic side effects of eyedrops is extremely important for the primary care physician. These reactions may represent a toxicity or idiosyncratic reaction. Onset of symptoms are variable and may occur days to weeks after beginning therapy. Patients often neglect to include eyedrops in a drug history, and it becomes the physician's responsibility to obtain this information.

It is equally important for the attending ophthalmologist and the primary care physician to keep one another informed when changing therapy. For example, if the family physician suspects a patient's acute asthma or heart block is due to timolol, stop the drug. A letter to the ophthalmologist should follow, so that alternative glaucoma therapy can be started. Likewise, the eye physician should consult with the family physician when instituting a drug like timolol in a patient with a history of asthma or congestive heart failure.

Summary

Topical eyedrops can have serious systemic side effects. Non-ophthalmologists should familiarize themselves with these complications and consider them in the differential diagnosis of unexplained disease.

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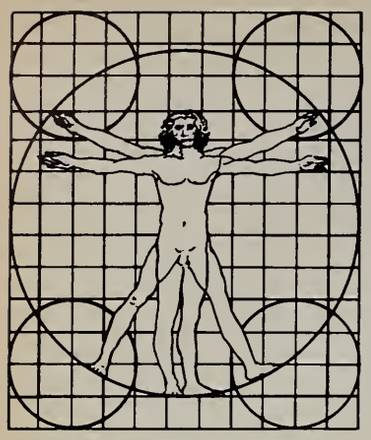
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Combination therapy suggested for insomnia

Treatment of insomnia should include psychotherapy, behavioral approaches and pharmacotherapy, alone or in combination, according to a National Institutes of Health consensus panel report. The report points out that one-third of the population report some degree of insomnia, and that 17% of the population consider insomnia a serious problem. "When pharmacotherapy is indicated, benzodiazepines are preferable," the report says, adding that dosage and period of use should be controlled carefully.

— *Journal of the American Medical Association*



CLINICAL & SCIENTIFIC

THE ASSOCIATION BETWEEN ELECTRONIC FETAL MONITORING AND CESAREAN SECTION RATE IN A PRIVATE COMMUNITY HOSPITAL

Thomas G. Kirkhope, MD
Amrutha Bhakthavathsalan, MD
Constance Roth, RNC

The indications for cesarean delivery in a private community hospital were reviewed. Period A, the last five (5) years prior to the introduction of electronic fetal monitoring (EFM) was compared to Period B, a five (5) year period during which EFM was in use. The cesarean birth rate rose from 5.0% in Period A to 15.1% in Period B, and cesarean delivery for fetal distress increased from 0.1% to 1.5%, i.e. only 11.9% of the increase in cesarean rate. At the same time, repeat cesarean was responsible for 30.7% of the increase, dystocia for 26.7%, breech presentation for 13.9%, and all other indications for 16.8% of the increased cesarean rate. Therefore, EFM is associated with only a minor portion of the overall increase in cesarean rates.

THE STEEP INCREASE in cesarean births in the United States in the last 10 years is a cause for concern. The concurrent rise in the use of the electronic fetal monitor (EFM) has led to speculation that excessive interpretation of fetal distress on such monitor recordings may be a major contributing factor.[1] Several reports, however, have indicated that other factors may play a more important part in explaining this increase.[2-5]

Most of these studies have been conducted in university hospital settings, where departmental chairmen can exercise considerable control over the obstetrical care rendered. The present study was undertaken in a community hospital to determine whether the contributing factors were significantly different in a patient population cared for by a more heterogenous group of physicians in independent private practice.

The Toledo Hospital is a 728-bed community hospital serving as the regional perinatal center for Northwest Ohio, with approximately 4,000 deliveries per year. The majority (83%) are delivered by private physicians, predominantly board-certified, or eligible, obstetricians. The remaining 17% are classified as "clinic" patients and are cared for by resident physicians, under the supervision of the Obstetrical or Family Practice attending staff.

Electronic fetal monitoring was first introduced at The Toledo Hospital in 1971. Forty-three percent of all patients are now electronically monitored in labor.

Materials and Methods

For this study, two time periods have been selected for comparison: Period A (1966 through 1970), a five year period prior to the introduction of the electronic fetal monitor; and Period B (1976 through 1980), a five year period during which the monitor has been in use. Records of all cesarean births performed at The Toledo Hospital during these periods were reviewed for indications for surgery. Criteria established by the NIH Consensus Development Statement on Cesarean Childbirth[6] were used to categorize these indications, as follows:

1. Previous cesarean births: Until very recently, previous cesarean was viewed as an absolute indication for repeat cesarean. Therefore, in the time span covered by this study, the only vaginal deliveries which occurred in women with previous cesarean births, were inadvertent.
2. Dystocia: This category includes all cesareans performed for "Cephalopelvic Dysproportion," "Feto-pelvic Dysproportion," "Failure to Progress," "Failure to Descend," and other similar designations, indicating the physician's decision to terminate labor because of lack of progress.
3. Breech presentation: Includes all cesarean births for which "Breech Presentation," of any type, was given as the primary indication.
4. Fetal Distress: Includes those cesareans done primarily for this indication, as shown on the patient's chart. In Period B, most, but not all of these were based upon interpretation of the electronic fetal monitor record.
5. All others: Includes all cesarean births done for indications not mentioned above, including malpresentations other than breech, placenta previa, toxemia, etc.

If more than one indication was given the patient's record for cesarean delivery, the one designated by the attending physician as the primary indication was used.

From the Section of Maternal-Fetal Medicine
Northwest Ohio Regional Perinatal Center
Northwest Ohio Center for Women & Children
Submitted March 21, 1984

Results

During Period A, 16,939 mothers were delivered at The Toledo Hospital. Of these, 855, or 5%, were cesarean births. In Period B, 17,873 mothers were delivered. Of these, 2,694, or 15.1%, were by cesarean birth. The difference in cesarean rate between Period A and Period B, therefore, is 10.1%. (See Table I)

There were 392 cesarean deliveries performed in Period A with "Previous Cesarean" given as the primary indication for cesarean birth. This represented 2.3% of the total number of deliveries in that period. In Period B, 961 cesareans, or 5.4% of the total deliveries, were performed for this indication — an increase of 3.1%. "Previous Cesarean" represented 30.7% of the total increase in cesarean rate from Period A to Period B.

In Period A, there were 463 primary cesarean deliveries, or 2.7% of the total deliveries during this time. In Period B, there were 1,733 primary cesareans, or 9.7%, of the total deliveries — an increase of 7%. These accounted for 69.3% of the total increase in rate of cesarean births.

Among the primary cesarean births in Period A, 179 were performed for dystocia. This represented 1% of the total deliveries in Period A. In Period B, 666 cesareans, or 3.7% of the total deliveries, were done for this indication. This represented an increase of 2.7%. This was 26.7% of the increase in cesarean rate which occurred from Period A to Period B.

In Period A, 16 primary cesarean deliveries were performed for breech presentation. This was 0.1% of the total deliveries. In Period B, 274 primary cesareans were done for this indication — 1.5% of the total deliveries. This was an increase of 1.4% and accounted for 13.9% of the increase in cesarean rate from Period A to Period B.

"Fetal Distress" was the indication for primary cesarean delivery in 27 patients, or 0.2% of the total deliveries, in Period A. In Period B, it was the indication in 241 patients, or 1.4%, of the total deliveries. This represented an increase of 1.2% and accounted for 11.9% of the increase in cesarean rate from Period A to Period B. The majority of these patients were electronically monitored in Period B.

In Period A, 241 primary cesarean deliveries were performed for indications other than the above. This represented 1.4% of the total deliveries during this time. In Period B, 552 primary cesareans were performed for these other indications — 3.1% of the total number of deliveries. The increase from Period A to Period B for "other indications" was 1.7%, representing 16.8% of the increase in cesarean birth rate.

Comment

Rapidly increasing rates of cesarean delivery have been noted throughout the United States in recent years. Frequently, this increase has been attributed to greater utilization of EFM. Numerous studies have attempted to evaluate the factors contributing to such a trend. At Wayne State University, Amirikia et al[2] found that the major portion of the increase was in primary cesarean births, repeat cesareans remaining essentially unchanged. Among the primary procedures, the diagnosis of "dystocia" accounted for the largest proportion of the increase in primary cesareans, fetal distress contributing only approximately 15%.

Boehm et al[5] described an increase rate at Vanderbilt University from 9.2% in 1970 to 17% in 1979. (Routine electronic fetal monitoring of all patients in labor was initiated at that institution in 1973.) Fetal distress as an indication for cesarean delivery accounted for only 6.4% of the overall increase in rate.

The collaborative study from NIH[6] noted an increase in cesarean birth rate in the United States from 5.5% in 1970 to 15.2% in 1978. NIH also found this trend in other countries. Fetal distress and breech presentation ranked third as major contributors in the rise of cesarean birth rates, accounting for 10% to 15% of the increase.

The majority of these studies were carried out on University obstetrical services where some uniformity of approach could be assumed. The present study indicates a similar trend in a private community hospital. At this institution there were 241 cesarean deliveries performed for fetal distress in Period B. This represents 11.9% of the

TABLE I
Change in Cesarean Birth Rate from Pre-monitor to Monitor Era

	Period A (Pre-monitor Era) 1966-1970		Period B (Post-monitor Era) 1976-1980			
	#	(%)	#	(%)	%	% Of Increase
Mothers Delivered	16,939	(100)	17,873	(100)		
Cesarean Deliveries	855	(5.1)	2,694	(15.1)	+10.1	(100)
Repeat	392	(2.3)	961	(5.4)	+ 3.1	(30.7)
Primary	463	(2.7)	1,733	(9.7)	+ 7.0	(69.3)

TABLE II
Change in Primary Cesarean Section Rate by Indication From Pre-monitor to Monitor Era

	Period A Pre-Monitor Era 1966-1970		Period B Monitor Era 1976-1980			
	Number	(% of Total Deliveries)	Number	(% of Total Deliveries)	%	(% of Total Increase)
Primary Cesarean Deliveries	463	(2.7)	1,733	(9.7)	+7.0	(69.3)
Dystocia	179	(1.0)	666	(3.7)	+2.7	(26.7)
Breech	16	(0.1)	274	(1.5)	+1.4	(13.9)
Fetal Distress	27	(0.2)	241	(1.4)	+1.2	(11.9)
All Others	241	(1.4)	552	(3.1)	+1.7	(16.8)

Association Between Electronic Fetal Monitoring

continued

overall increase in cesarean rate. In 17 of these, the diagnosis was made in a labor which was not being monitored electronically. The actual contribution of EFM to the increase in cesarean birth rates, therefore, is probably even less than 11.9%. In addition, even in those cases where EFM was indeed responsible for the diagnosis of fetal distress, it may have been impossible to avoid cesarean delivery without compromising the fetus.

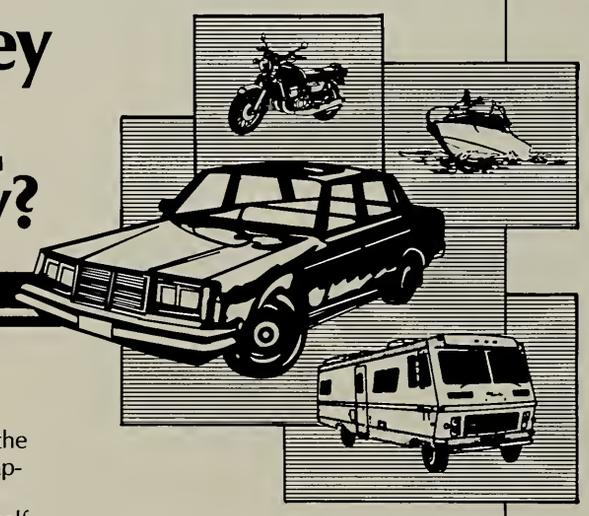
In contrast, over 50% of the increase in cesarean rate is attributed to two indications: repeat cesarean (30.7%) and dystocia (26.7%). This finding is similar to that of Amirika et al[2] at Wayne State University, Boehm et al[5] at Vanderbilt and Minkoff and Schwarz[3] at Downstate Medical Center, Brooklyn. The NIH Consensus Development study[6] showed that dystocia contributed 30% and repeat cesarean contributed 25% to 30% of the increase in cesarean rate. Cesarean delivery for fetal distress at The Toledo Hospital accounts for a relatively small percentage of the total number of cesareans performed, even in the monitor era (241 of 2694, or 8.9%). Although it may be possible to reduce this number by the addition or increase utilization of fetal scalp blood sampling, as recommended by Tejani et al[7] and by Zalar and Quilligan,[8] reduction in cesarean deliveries for fetal distress will produce only a small decrease in the overall cesarean rate.

In conclusion, fetal distress accounts for a relatively small percent of the increase in cesarean rate at The Toledo Hospital. Fetal distress with diagnosis made by EFM accounts for even less. Therefore, efforts to reduce the cesarean birth rate by reducing those performed on the basis of the EFM record, will produce, at best, only a small reduction in the overall cesarean birth rate.

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OHIO (CENTRAL AND NORTHERN AREAS): Seeking Emergency Medicine physicians for full time and locum tenens opportunities in attractive moderate volume facilities. Directorships also available. Competitive hourly rates, malpractice insurance and flexible scheduling. For more information contact: Emergency Consultants, Inc, 2240 S. Airport Rd., Suite 128, Traverse City, MI 49684; 800-253-1795 or in Michigan 800-632-3496.

PHYSICIAN WANTED. General office practice, small private clinic. Columbus, Ohio. 35 hrs. per week. $40,000 base salary — plus percentage. Prefer age 30 to 45 yrs. Reply with brief summary to Box No. 27, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

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Colleagues In The News

Edited by Doug Evans

JOHN BERGFELD, MD, Cleveland, head of the sports medicine department of orthopedic surgery at the Cleveland Clinic, was recently elected to the board of trustees of the Cleveland Ballet.

FOSTER J. BOYD, MD, Wilmington, has been elected medical trustee for district 14 of the American Cancer Society, Ohio Division, Inc. Dr. Boyd has served as the society's state and national president, and now serves on the national House of Delegates.

J. FREDERICK DOYLE, MD, South Vienna, was recently recognized for 50 years of active practice by the American Medical Association and the American Academy of Family Practice.

MARTHA FRANZ, MD, Dayton was elected to Alpha Omega Alpha Epsilon Chapter at Wright State University. The national honor society recognizes and promotes excellence in the medical profession.

WILLARD J. HOWLAND, MD, Canton, has been awarded the Silver Medal Award by the Ohio State Radiology Society. Dr. Howland received the award for meritorious service to his patients, his profession and the radiology society.

ALLEN JACKSON, MD, Bryan, was recently honored by the Medical College of Ohio for his part in the development of the Area Health Education Center program in northwest Ohio. He was honored at the Bryan Kiwanis Club meeting which declared July 18 as "Dr. Allen Jackson Day."

ARTHUR G. JAMES, MD, Columbus, has been named medical director of the Cancer Research Institute at the Ohio State University. Dr. James will oversee the building of the staff and establishment of programs for the facility which is scheduled to be completed in 1987.

ROGER D. JENKINS, MD, Lima, has been elected to the Board of Trustees of the American Cancer Society, Ohio Division, Inc.

OWEN JOHNSON, MD, Columbus, was recently elected president of the medical and dental staff of Riverside Methodist Hospital in Columbus. Other officers elected include DAN McFARLAND, MD, Worthington, president-elect; JAMES BAIRD, MD, Columbus, immediate past president; EDWARD KRUG, MD, Worthington, chairman of the Department of Psychiatry; and JOHN GOFF, MD, Worthington, chairman of Obstetrics and Gynecology.

JOHN C. KELLEHER, MD, Toledo, has been elected president-elect of the American Association of Plastic Surgeons. He will assume the duties of president in May, 1985.

SHAKIL KHAN, MD, Toledo, has been named Director of Medical Services at the Center for Health Promotion.

WAEL A. KHOURY, MD, Shaker Heights, has been appointed to serve as director of cardiology at Community Hospital of Bedford, Ohio.

KENT A. KNAUER, MD, Cleveland, has been named medical director of the new Mednet Beachwood Clinic. He is also head of the Mednet Allergy and Asthma Clinics in Euclid and Mentor.

WILLIAM A. MAST, MD, Cleveland, was recently named director of the Division of Surgery at the Hillcrest Hospital.

STEPHEN NEWMAN, MD, and DWIGHT TUURI, MD, were recognized for their outstanding achievements in medicine at the annual dinner of the Wright State University Academy of Medicine. Dr. Tuuri received the academy's Professional Excellence in Medical Practice Award. Dr. Newman received the Excellence in Medical Education and Research Award.

HERSCHEL RHODES, MD, Upper Sandusky, was recently honored by the Wyandot Memorial Hospital for his 30 years as an active practicing physician.

LEN SCARPINATO, DO, Cleveland, was the Assistant Chief Medical Officer for the United States Olympic Team in Los Angeles. Dr. Scarpinato's duties during the five-week period included scheduling the medical support personnel and treating athletes and personnel involved in the games.

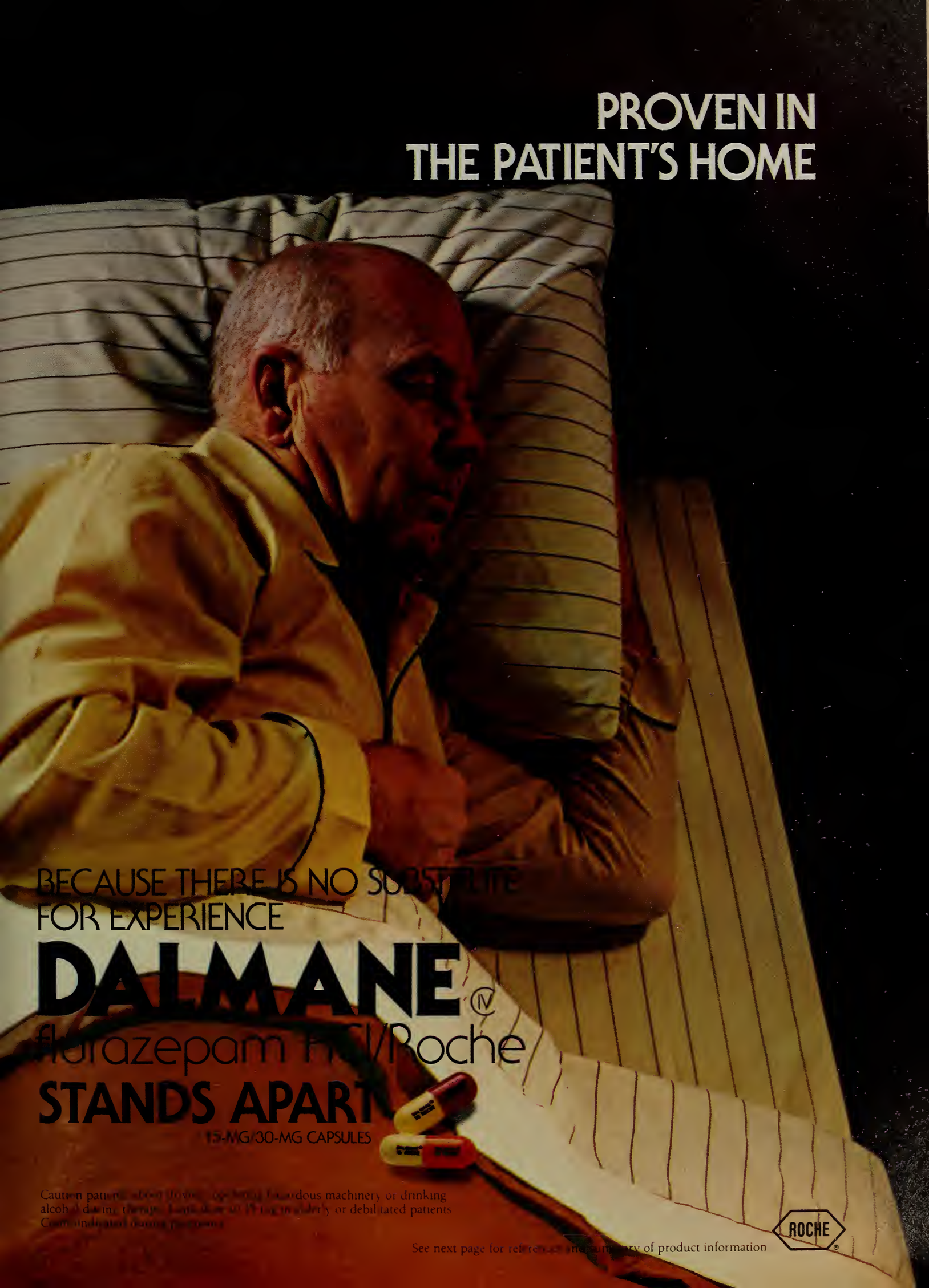
SELIG S. STRASSMAN, MD, Cleveland, has been elected to the Executive Committee Section Adolescent Health of the American Academy of Pediatrics.

JOSEPH F. TOMASHEFSKI, MD, Cleveland, was elected first vice president of the American Lung Association of Northern Ohio. Dr. Tomashefski has been involved with the association since 1983 when he was elected to the board of trustees. He has served as secretary and second vice president.

WILBURN WEDDINGTON, MD, Columbus, has been elected president of the Ohio Academy of Family Physicians. Other officers elected include THOMAS U. TODD, MD, Cincinnati, president-elect; TERENCE P. TORBECK, MD, Dayton, vice president and national alternate; CHARLES W. SMITH, JR., MD, Dayton, treasurer; V. FRANKLIN COLON, MD, Cincinnati, speaker of the house; DAVID L. HOFF, MD, Akron, vice speaker; GLEN F. AUKERMAN, MD, Jackson Center, national delegate; LEROY A. ROGERS, MD, Toledo, OSMA delegate; and GENE A. WRIGHT, MD, OSMA alternate.

KENNETH A. WEINER, MD, Lakewood, has been elected president of the Ohio Chapter of the American College of Emergency Physicians.

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See next page for references and summary of product information

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1984 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

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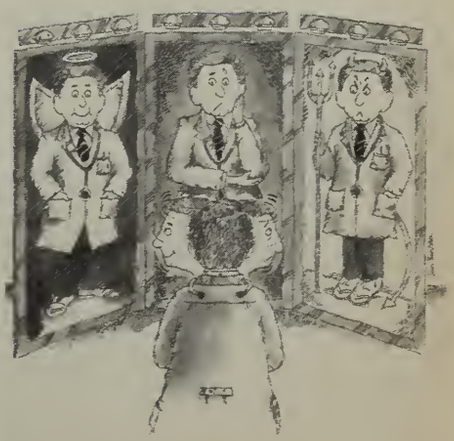
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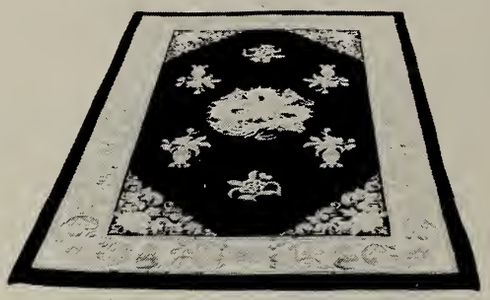
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Date of Filing September 21, 1984. The Ohio State Medical Journal (ISSN 0030-1124) is published monthly at 600 S. High Street, Columbus, Franklin, Ohio 43215 with headquarters or business offices of the publishers at 600 S. High Street, Columbus, Ohio 43215. The name and address of the publisher The Ohio State Medical Association, 600 S. High Street, Columbus, Ohio 43215. Editor, Karen S. Edwards, 600 S. High Street, Columbus, Ohio 43215. Managing Editor, Hart F. Page, 600 S. High Street, Columbus, Ohio 43215. Owner of the publication is the Ohio State Medical Association (a corporation, not-for-profit with no stock outstanding). There are no bondholders, mortgagees or security holders.

Total number of copies printed (average for preceding 12 months) 18,724; sales through dealers — none; mail subscriptions 18,280; total paid circulation 18,280; free distribution 94; total distribution 18,374; office use, etc. 350; returns from news agents — none; total 18,724. Actual number of copies printed (single issue nearest to filing date) 18,384; sales through dealers — none; mail subscriptions 18,084; total paid circulation 18,084; free distribution — none; total distribution 18,084; office use, etc. 300; returns from news agents — none; total 18,384.

I certify that the statements made by me above are correct and complete.

Karen S. Edwards, Executive Editor

Have You Checked Your Image Lately?

Like it or not, doctor, you have an image. Whether or not that appears to be a problem depends, to a large extent, on whom you ask.

If you ask your patient what he or she thinks of you, chances are you'll be pleased. Studies show that the majority of today's public think highly of their own personal physician — and they don't mind telling others so.

But your halo begins to slip the minute you pose the question to the man on the street. He may like his own physician, but he's worried about everybody else's. You see, studies also show that physicians, as a group, are held in low esteem by the American public.

So, the point is, doctor, you have *two* images — the one your patient sees and the one the public sees. Which is the most accurate?

Well, probably neither. You're aware of your own limitations and know that miracles aren't really part of your standard black-bag equipment. But neither are you the cold, heartless individual which is the way you're sometimes depicted.

According to "The Environment of Medicine," a report of the American Medical Association's Council on Long Range Planning and Development:

"The difference between the views expressed toward physicians as a group and the attitudes surrounding the last physician visit suggest that the public image of physicians is strongly influenced by factors other than personal experience. It is likely that opinions and views expressed by the media have a strong impact on the public image of physicians."



Studies show that the majority of today's public think highly of their own personal physician — and they don't mind telling others so. But your halo begins to slip the minute you pose the question to the man on the street.

This issue of the *Journal* attempts to explore the validity of that assumption. Does the media really have a strong impact on physician image? If so, what kind of impact is made, and how is it achieved?

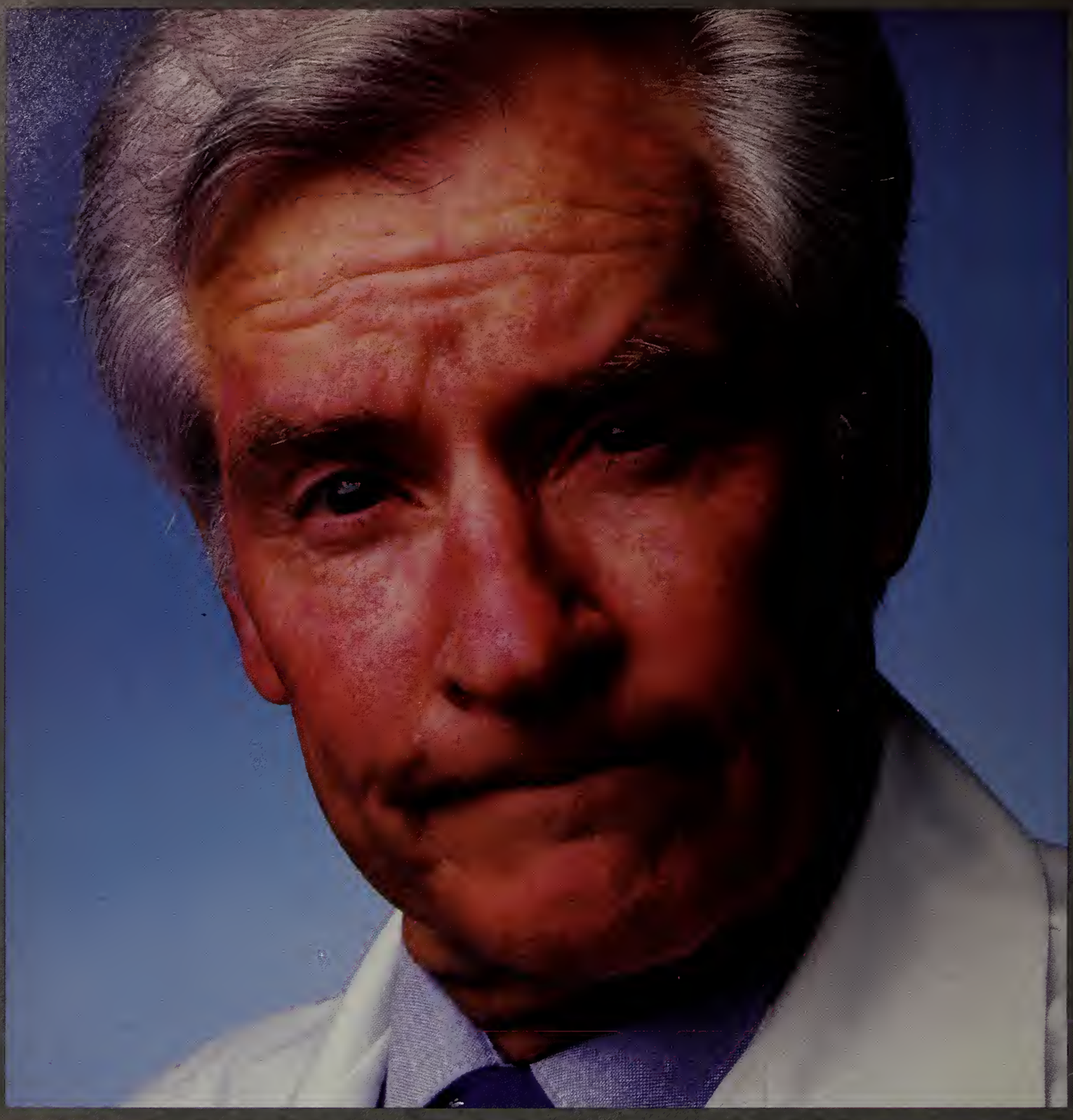
For answers, we've turned to the media themselves. We've taken a look at how physicians are depicted on film, in print, and on TV.

We've included an article on the media-training seminars, conducted over the past six years by the Department of Communications. These seminars have been designed to give you a better idea of what it is the media wants from you, and the best way to present it to them.

We've also tapped the Communications Committee for a discussion of marketing your image and the profession's image — is it worth doing and why?

You may find the answers to these questions alarming, surprising, pleasing — for image is really a personal thing, and as fleeting as a moment of time.

But perhaps there is some consolation in the fact that, good or bad, a physician image does exist, and has existed from the days of Hippocrates. After all, as most communications experts will tell you, the only thing worse than a bad public image is absolutely no image at all. — *Karen S. Edwards*



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Nicotine Chewing Gum—An Adjunct to Smoking Cessation

By Mark Schuyler, MD and Charles B. Payne, Jr., MD

Editor's Note: *The following article has been prepared as a position statement of the Ohio Thoracic Society on the subject of nicotine chewing gum.*

Nicotine chewing gum has recently received FDA approval as a prescription drug for patients who want to stop smoking. Each flat square of gum contains two milligrams of nicotine. The gum, called Nicorette® (Merrell Dow Pharmaceuticals, Inc.), is designed to relieve symptoms arising from physical dependency on nicotine. Although no means to identify smokers with physical dependency currently exists, the FDA suggests that those who inhale, who smoke more than 15 cigarettes daily, who require a cigarette on arising, or who smoke a brand with more than 0.9 mg of nicotine per cigarette, are most likely to be physically dependent.

Contraindications to nicotine gum include: pregnancy and lactation; life-threatening cardiac arrhythmias, severe or worsening angina pectoris; the period immediately following myocardial infarction; and active temporomandibular joint disease. Physicians may wish to order a pregnancy test before initiating nicotine gum therapy in women of child-bearing age. The use of the gum is usually self-limiting, with maximum usage occurring in the first three to four months after smoking cessation. Using the gum more than six months is not recommended.

In our opinion, management of physical dependency alone constitutes incomplete treatment of patients who quit smoking. The use of anorexiogenic medications without dietary retraining, psychological support, and exercise programs in attempting lasting weight reduction and control is an example of inadequate therapy. Cigarette smoking is a complex behavioral issue with a variety of programs available to assist individuals who wish to quit.

As the medical advisory arm of the Ohio Lung Association, the Ohio Thoracic Society does not endorse nicotine-containing gum, nor any other smoking cessation program or commercial product advertised for lung health, except those developed by the American Lung Association. It is apparent, however, that nicotine chewing gum has been the subject of independent investigation with publication in peer-reviewed journals indicating that the gum appears to work in relieving the symptoms arising from the physical dependency on nicotine manifested by many smokers.

The role of nicotine chewing gum is not yet well defined, and long-term data regarding its efficacy remain to be gathered and analyzed. The Ohio Thoracic Society welcomes any product of merit that aids in smoking cessation efforts, but recommends that physicians approached for information or prescriptions for nicotine chewing gum combine its use with other effective smoking cessation programs available in their area. Programs such as Freedom from Smoking®, available from branches and affiliates of the American Lung Association, are designed to provide incentives and support to the patient during cigarette withdrawal. These programs provide the educational material to promote long-term smoking cessation.

The Ohio Thoracic Society recommends that nicotine chewing gum be considered as an adjunct to existing antismoking programs. Long term studies need to be conducted to establish the role of nicotine gum. It should not become a temporary and repetitive crutch in the fashion of "diet pills."

Mark Schuyler, MD, is President of the Ohio Thoracic Society.

Charles B. Payne, Jr., MD, is past president of the Ohio Thoracic Society and is Director-at-large, American Lung Association.

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NEWS

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edited by Susan Porter

More on medical students

Although more medical students and residents than ever before are in the medical education system today, first-year enrollments continue to decline, says the 84th Annual Report on Medical Education.

The report, which was issued shortly after publication of the *Ohio State Medical Journal's* special September issue on medical students says that total enrollment in US medical schools rose by less than 1% in 1983-84. First year enrollment has been declining for the past three years.

The average education debt reported by senior students was nearly $24,000, according to the report, while more than 13% of the graduating class of 1983 reported debts of at least $30,000. However, scholarship funds decreased by 8% and loan funds were down 4% from the previous year.

One out of every three new medical students is a woman the report indicates, while approximately 16% are members of ethnic groups. Approximately 5% of the medical student population is black.

The report, which appears in full in a recent issue of the *Journal of the American Medical Association*, also notes an increase in the number of U.S. citizens who are attending foreign medical schools.

Meanwhile, the physician population in the United States increased by 3.8% between 1982 and 1983, according to preliminary data released recently by the AMA. That number rose from 501,958 in 1982 to 519,403 in 1983.

That study also indicates a greater representation of women in the medical profession. While the total number of physicians increased 11.1% between 1980 and 1983, the total number of women physicians grew by 28.9% over that same time period.



Project USA needs physicians

Physicians interested in serving for short periods of time in underserved areas should contact Project USA, an American Medical Association program which supplies physicians for short-term general medicine assignments in rural areas, from Maine to California and Alaska to Florida.

The program, now in its 11th year, was recently awarded another three-year contract by the Health Resources and Services Administration.

Project USA provides replacements at Indian Health Service and National Health Service Corps hospitals and clinics throughout the nation, so that full-time physicians at those locations can take brief leaves for continuing education, vacation and other purposes.

Physicians involved in Project USA receive $500 a week, roundtrip coach fare, housing and meals.

Those wishing more information may contact John Naughton, AMA, 535 North Dearborn, Chicago, Illinois 60610 or may call (312) 645-4702.

CT effective in determining brain death

Researchers at the University of Pittsburgh and the General Electric Company's Medical Systems Group have successfully demonstrated the use of Computed Tomography (CT) as a clinical tool to explore brain function, as opposed to anatomy. The group used inhaled xenon gas to enhance cerebral blood flow images.

The tool is seen as especially effective as an additional method of determining brain death, "both from a humane viewpoint and as a cost factor to the patient's family, who in the face of uncertainty may opt for continuance of life support systems," says one of the researchers.

According to the researchers, the method also is useful in the management of many neurological conditions, including stroke, seizure, trauma, aneurysm and dementia, as well as in the study of coma and brain death.

Cerebral blood flow mapping may also be used to ascertain whether surgery is indicated to augment blood flow when ischemia is present.

Drug Capsules

New drug for herpes

Acyclovir capsules have been proven effective in reducing the duration and discomfort associated with first episodes of genital herpes simplex virus infection, according to the findings of researchers from three United States and two Canadian medical centers.

Colleagues from the University of Washington School of Medicine in Seattle and four other institutions recently conducted a double blind study using the drug and placebo. The results were published recently in the *Journal of the American Medical Association.*

Those patients with nonprimary first-episode genital herpes who received the oral acyclovir responded better than the placebo recipients in terms of median duration of viral shedding, time to crusting of lesions, time to healing of lesions, duration of local pain and duration of constitutional symptoms, such as headache, malaise, muscle aches, light sensitivity and fever.

Among patients with nonprimary first-episode genital herpes, oral acyclovir shortened the median duration of viral shedding but had no significant effect on the duration of lesions or symptoms. The drug also appeared to have no influence on subsequent recurrences in these patients.

The researchers warn, however, that the drug is not a "cure" for genital herpes, and thus patients should be counseled about the likelihood of subsequent recurrences of the disease and of the increased risk of transmitting disease during these recurrences.

Steroid aerosol now available for asthma sufferers

The U.S. Food and Drug Administration recently awarded Key Pharmaceuticals, Inc. its approval to market the first twelve-hour steroid aerosol for the treatment of bronchial asthma.

The product is to be marketed under the trademark AeroBid, and was developed by Syntex Pharmaceuticals International, Ltd.

The active component in AeroBid is flunisolide, an anti-inflammatory steroid. The twice-a-day dosage regimen will be available only on a prescription basis, in order to assure chances of patient compliance.

Suspect virus may not be sole AIDS cause

Before concluding that acquired immune deficiency syndrome (AIDS) can be prevented by a vaccine for human T-cell leukemia virus (HTLV-III), a great deal more evidence must be obtained that HTLV-III is the sole cause of AIDS, writes Arthur J. Ammann, MD, of the University of California School of Medicine, San Francisco. He points out that some patients with AIDS lack antibody to HTLV-III or detectable virus, while others in AIDS risk categories have antibody or detectable virus but no signs of AIDS. Evidence suggests that a single agent by itself is not capable of causing AIDS, "but that other factors, such as additional viral infections or preexisting immunosuppression, are prerequisite for the development of AIDS," he concludes.

Nutrition booklet available

Adverse Reactions to Foods is the title of a new book produced recently by the American Academy of Allergy and Immunology and the National Institute of Allergy and Infectious Diseases.

Designed for the general practitioner, along with other health care personnel specializing in gastroenterology, pediatrics and nutrition, the book represents a consensus on the state of the art in the highly complex, enigmatic and controversial area of adverse food responses, according to its publishers.

The book's 24 contributors cover such topics as chemistry of selected food antigens, the fate of food antigens in the digestive tract, immunologic and nonimmunologic food reactions, diagnosis and treatment of adverse food responses and avoidance of specific foods, prior to known sensitization, in potentially susceptible infants.

It also includes an extensive appendix listing diseases transmitted by foods.

The book is available through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 (Stock No. 017-044-00045-1) for $9.50.

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Children With Special Needs — A Priority

By Daniel Lee Coury, MD and Antoinette P. Eaton, MD

During the past two decades the monumental advances that have occurred in perinatal-neonatal medicine have resulted in a remarkable ability to prolong life and enhance the survival of high risk neonates. This has raised serious questions among physicians and government agencies about possible increase in the total numbers of individuals with disabling conditions that will result and the importance of appropriate planning to meet the medical and educational needs of this special population.

It is theorized that advances in neonatal medicine increase survival at the expense of increased developmental problems; however, recent data indicate that this is not so. The incidence of minor congenital anomalies and developmental delay has actually declined according to one study.[1] In contrast, the identification of less severe disabilities, especially learning disabilities, has increased. The following discussion will focus on how the special needs of handicapped children, particularly their educational needs, have been met until recently, and the value of continued funding and resource allocation to serve this population.

The idea that society and the disabled would mutually benefit from education was not strongly stated until supportive data became available from intervention programs in the early 1960s.

In the past, society has often looked upon disabled persons as they look upon other "minorities." They are seen as inferior to those without handicaps. Great strides have been made to reverse the effects of this attitude through legislation which requires equal opportunity for employment, access to public places, and education for the handicapped and all persons regardless of race, sex or creed. Proposed federal funding cutbacks threaten the effectiveness of this legislation for handicapped persons at a time when the numbers of identified disabled persons may be increasing.

The medical profession has assisted in changing society's perceptions and treatment of the disabled. The first significant moves came in the late 18th century with medical explanations for illnesses and handicaps, replacing popular and religious theories (such as God's displeasure with the afflicted person). Education and habilitation

followed in the early 19th century, and Ohio was one of the first states to establish institutions for the teaching of the blind and deaf. The goals of these early institutions were modest and stressed self-help and communication skills rather than career training.

Over the next century education for handicapped children made variable progress from state to state, reflecting local attitudes and resources. The idea that society and the disabled would mutually benefit from education was not strongly stated until supportive data became available from intervention programs in the early 1960s. The federal government finally became involved and enacted PL 89-750, in 1966 establishing the Bureau of Education for the Handicapped. PL 91-517 in 1971, addressed the issue of developmental disabilities and established the University Affiliated Facilities for training health professionals, as well as treating disabled youngsters. However, these measures were not adequate.

In the school year 1974-1975, 4.25 million handicapped children, out of a total of 8.7 million, were not receiving an appropriate education.[2] Of these, more than a third were receiving no education. This widespread failure to meet the needs of handicapped children prompted Congress to enact PL 94-142, the Education for All Handicapped Children Act, and PL 94-585, the Rehabilitation Act of 1975.

Of these, it was PL 94-142 which had the most far-reaching effects on education for the handicapped. It applied to the mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, emotionally impaired, other health impaired, multiple handicapped, and children with specific learning disabilities. This law instituted very few new programs, but did establish minimum standards for existing programs. It recognized the responsibility of state and local governments to provide services regardless of federal expenditures. Thus, although the law requires communities to provide "an appropriate education," this education can vary according to the standards each community establishes for its children.



Children with learning disabilities will represent a major economic problem as adults in the "information age" where the ability to use new technology is much in demand, unless they receive the proper training and education.

PL 94-142 does not define a role for physicians, but physician involvement is strongly implied. State laws concerning disabled children vary, with some specifying clearly the role of the physician in the multidisciplinary assessment of the handicapped child. The American Academy of Pediatrics, the American Board of Pediatrics, and the Task Force on Pediatric Education have all emphasized the need for pediatricians to become more involved with child development, especially as it pertains to the education of handicapped children.[3] Several commentaries have also described the role of the physician as child advocate in supporting such legislation. The public also plays an important role in seeing that the needs of children are being met. Public demand has been responsible for a great many child care programs, including Head Start, WIC, and PL 94-142 itself; any proposed changes will need to receive public approval.

The economic aspects of providing these services must be considered. PL 94-142 was intended to set a minimum standard but placed the responsibility on the state and local communities; federal funding was never intended to provide the major program support. In Ohio, federal monies have accounted for less than 10% of special education funds for the past four years.[4] Any cutbacks at a federal level should result in minimal changes in services (and appropriately so). The potential economic hazards of failure to provide an appropriate education to disabled children are similar to those situations surrounding newborn screening for hereditary metabolic disorders.[5] There already is appreciation, at a governmental level, for the benefit of such programs, as well as for the State Crippled Children's and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Programs. Early identification and treatment of children with developmental handicaps is a logical extension of this philosophy.

Such early identification, particularly of learning disabilities, results in increased numbers of children requiring special education. Federal figures reveal that four million children were enrolled in special education programs for the 1981-1982 school year. In Massachusetts, they accounted for 16% of all children in grades kindergarten through 12. Children with learning disabilities will represent a major economic problem

as adults in the "information age" where the ability to use new technology is much in demand, unless they receive the proper training and education. The rising numbers of identified disabled and handicapped children will make more demands on an already stressed system by requiring "appropriate" education.

There is a need for continued and increased funding in this area from all levels of government. The criteria qualifying a student for special services are defined at community levels. Because local standards and facilities vary, local funds should constitute a substantial portion of these dollars. Programs for disabled children existed long before federal involvement because states appreciated the need for them, and state funds should also continue to be a major segment. However, the federal government should play a more significant role in this area. Federal monies should be appropriate to needs in an effort to balance those areas lacking in resources with those having them in abundance. Federal funding can also encourage states and local programs through matching dollars for services, as well as promote research into the treatment and prevention of disabilities.

CONCLUSION

Recognition of the problems of disabled persons, and the benefits to society of habilitation of this population, has increased dramatically in the past twenty years. Federal legislation setting minimum standards for education of handicapped children has been vital in improving programs for the disabled. During a period when the total number of disabled persons identified is increasing, prompt identification of infants and young children with developmental handicaps is critical. Early intervention programs to serve this population must become a high priority for the state and local educational system. Continued and improved funding at all levels of government for special programs is an investment of vital importance for the good of our society's future.

Daniel Lee Coury, MD is Assistant Professor of Pediatrics at Ohio State University. Antoinette P. Eaton, MD is Professor of Pediatrics and Preventive Medicine at Ohio State University, and Associate Medical Director of Columbus Children's Hospital.

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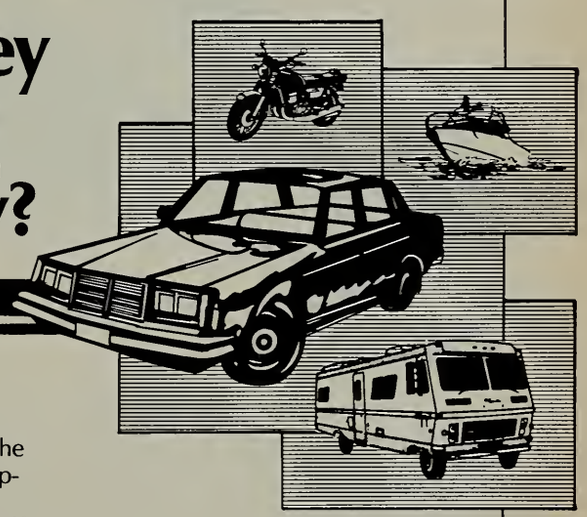
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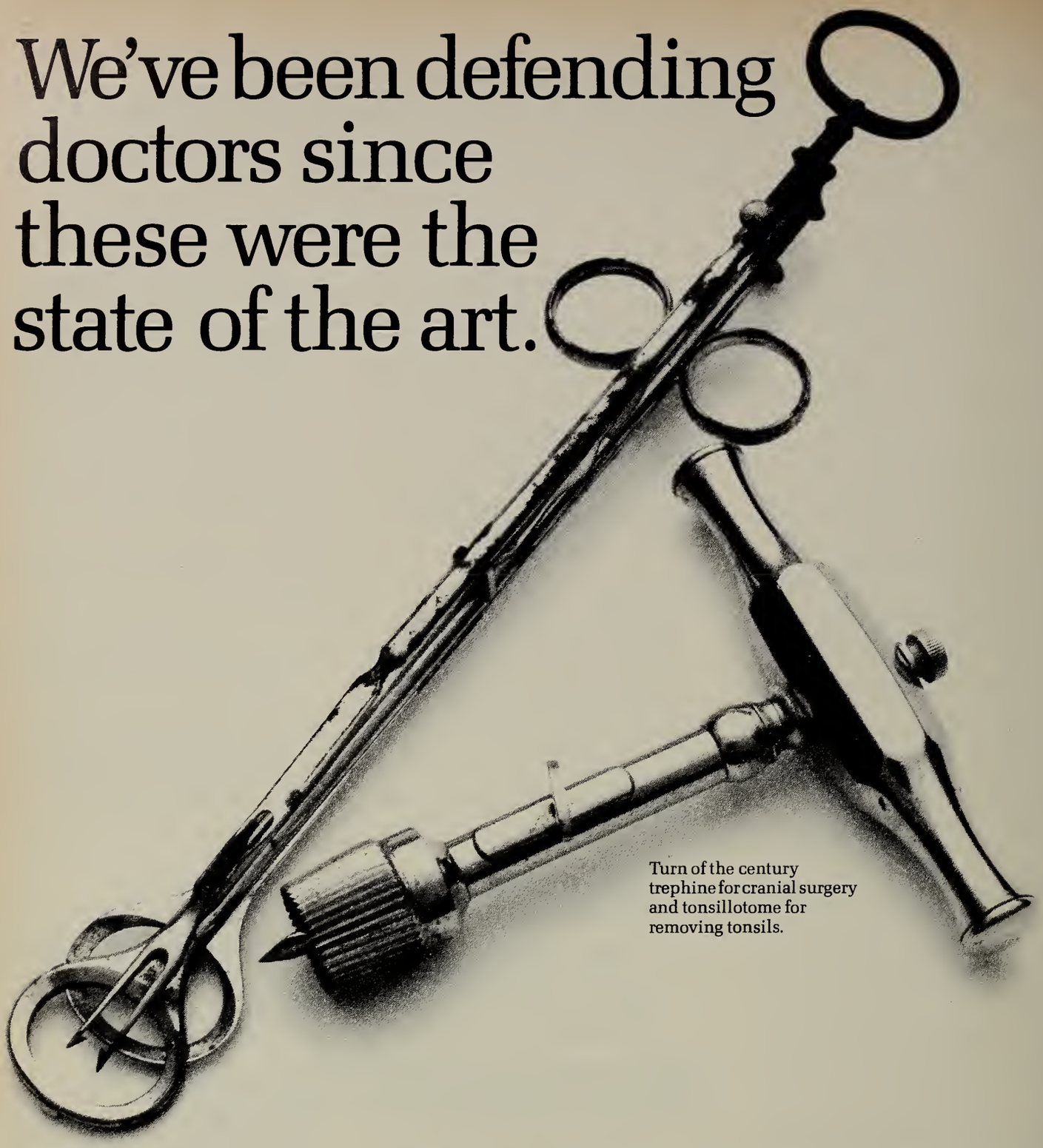
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Medicaid's Future: "It's Up to You"

By Carol Wright Mullinax

Editor's Note:
Patricia K. Barry became the new Director of the Ohio Department of Human Services earlier this year. Before assuming this position, Ms. Barry served as the Deputy Director in the department, then known as the Ohio Department of Public Welfare. Because part of her former duties included the administration, management and policy development of the state medicaid program, the **Journal** *felt she would be an appropriate interview source for an article on the state's public health programs — where they are, and where they are going . . .*

JOURNAL: What do you consider to be the top priorities of the Ohio Department of Human Services?

MS. BARRY: I always like to avoid saying "This is the most important thing we have to do." I think there are several major issues that we need to continue to work on and somehow we have to find a way to do it all at once.

However, because this department is responsible for caring for a lot of dependent people, one issue we are constantly looking at is how well we run our programs and interact with the counties who actually deliver the services — from being able to apply for and get on an income assistance program efficiently, to protective services programs for children, to making certain the food stamp delivery sites work efficiently. We need to keep our eyes on how well we actually deliver the services to the people we were designed to help.

JOURNAL: Obviously, the OSMA, as an organization representing more than 18,000 physicians, is interested in the Medicaid program. What are the major problems facing the Medicaid program?

"In three years, I would like to be able to say that half of our population is in primary health care, and that we have increased physician participation by 20%. I'm not sure that it will happen that fast . . ."

MS. BARRY: I think it is fair to say that the Medicaid program we have had for the past 12 years has been stagnant. Medicaid now has to come into the 20th Century. That's why we implemented prospective payment for hospital reimbursement on October 1.

With respect to physicians, the biggest change we want to make is to encourage the development of prepaid primary health care models for Medicaid recipients. I think if you look at our data on Medicaid, you'll see the majority of our people are not being seen by private physicians, but by hospital out-patient rooms, emergency rooms and special clinics. They are getting expensive care.

With the development of prepaid systems, however, we are hoping more physicians will agree to serve Medicaid patients, because we would like to see more primary care physicians managing the care of a family. I also believe that, as we move people out of expensive settings and into family health care, we can do a better job in terms of reimbursement.

In three years, I would like to be able to say that half of our population is in primary health care and that we

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have increased physician participation by 20%. I'm not sure that it will happen that fast because there is clearly, within the health industry a resistance to prepaid systems. Some physicians view it as socialized medicine. But if you look at both Medicare and Medicaid, they *are* forms of socialized medicine. They are publicly funded health programs which, when they became law, were thrown into a free marketplace and we *know* what the result has been — they have become tremendously costly, both to the federal and state governments. Perhaps now is the time, given the big trends in health care, for our program to go the way of prepayment and HMO development. Certainly, our first step at slowing costs is not to cut benefits nor eligibility, but to ask, "Is there a different reimbursement system that provides incentives, including monetary incentives, to the health care providers?" I don't see anything wrong with that, and it may save the program.

JOURNAL: What about the reimbursement levels for Medicaid? Physicians are being reimbursed at levels set in the late 1960s. Do you see any hope for an increased level of reimbursement for physicians?

MS. BARRY: Before the Medicare and Medicaid programs, we had physicians all over this country who gave time to care for the poor. As soon as Medicare and Medicaid came about, that donation of time literally disappeared across the country. It is important to remember that Medicaid does not guarantee care for the poor. We know that we probably only cover 50% of the people.

It also is important to keep in mind the tremendous amount of money Medicare and Medicaid have put into the health industry. We probably have doubled the size of revenues going into health care since 1965.

The real question is how do we take those resources and change the delivery systems so that *everybody* can benefit — so that the client or patient can have access to more personalized care and the physicians or health care provider can have reasonable reimbursement levels, giving them monetary incentives to practice in a cost efficient, meaningful way. To accomplish this we have to make some major changes, yet a lot of people aren't interested in change.

JOURNAL: In addition to prospective payment, which you have already mentioned, you have initiated several other programs which were designed to cut costs. Do you have a way of measuring how much impact these programs will have on the cost of administering Medicaid?

MS. BARRY: Yes. Last year was the first year Medicaid stayed under its budget. We estimate that we saved approximately $50-$70 million.

Pre-admission certification, prospective payment and now the primary health care and HMO push is clearly saying to the health care industry in Ohio that we are going to change the way we are doing business. It is giving the signal that we are no longer a stagnant program, that we are a dynamic program. Again, not everybody likes this.

JOURNAL: Since this article will be read by physicians throughout the state, do you have any message for Ohio physicians?

MS. BARRY: In the 1960s and before, physicians felt there was a mandated responsibility to give "X" number of hours a week to the care of the poor, with no consideration for reimbursement. Physicians today may have to begin committing part of their practice to serving the poor. If *all* physicians were willing to accept Medicaid patients, then the percentage of each physician's Medicaid patient population would be marginal.

We cannot be continually criticized for being an expensive program when our patients' real access to health care is through large, costly institutions.



Pat Barry, Director, Department of Human Services.

"We cannot be continually criticized for (Medicaid) being an expensive program when our patients' real access to health care is through large, costly institutions."

We can't change that on our own. We can work real hard and do everything we can to make this program cost efficient, but if we can't get community-based physicians willing and able to see our patients in their offices, then we are stuck with those large, costly institutions. **OSMA**

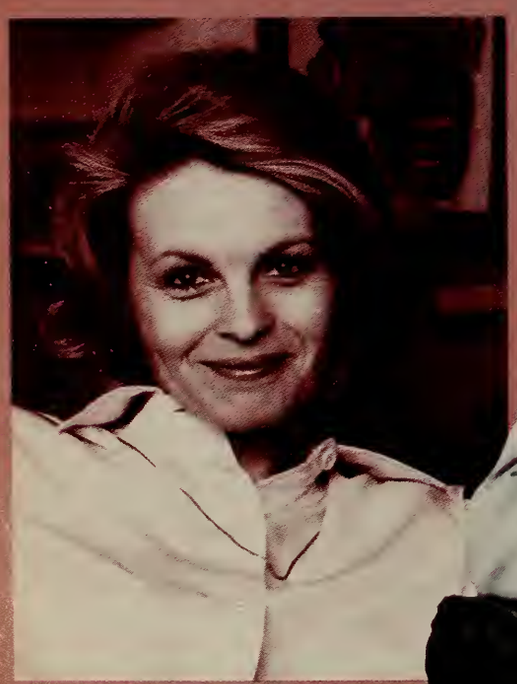
Carol Wright Mullinax is Director of the OSMA Department of Communications.

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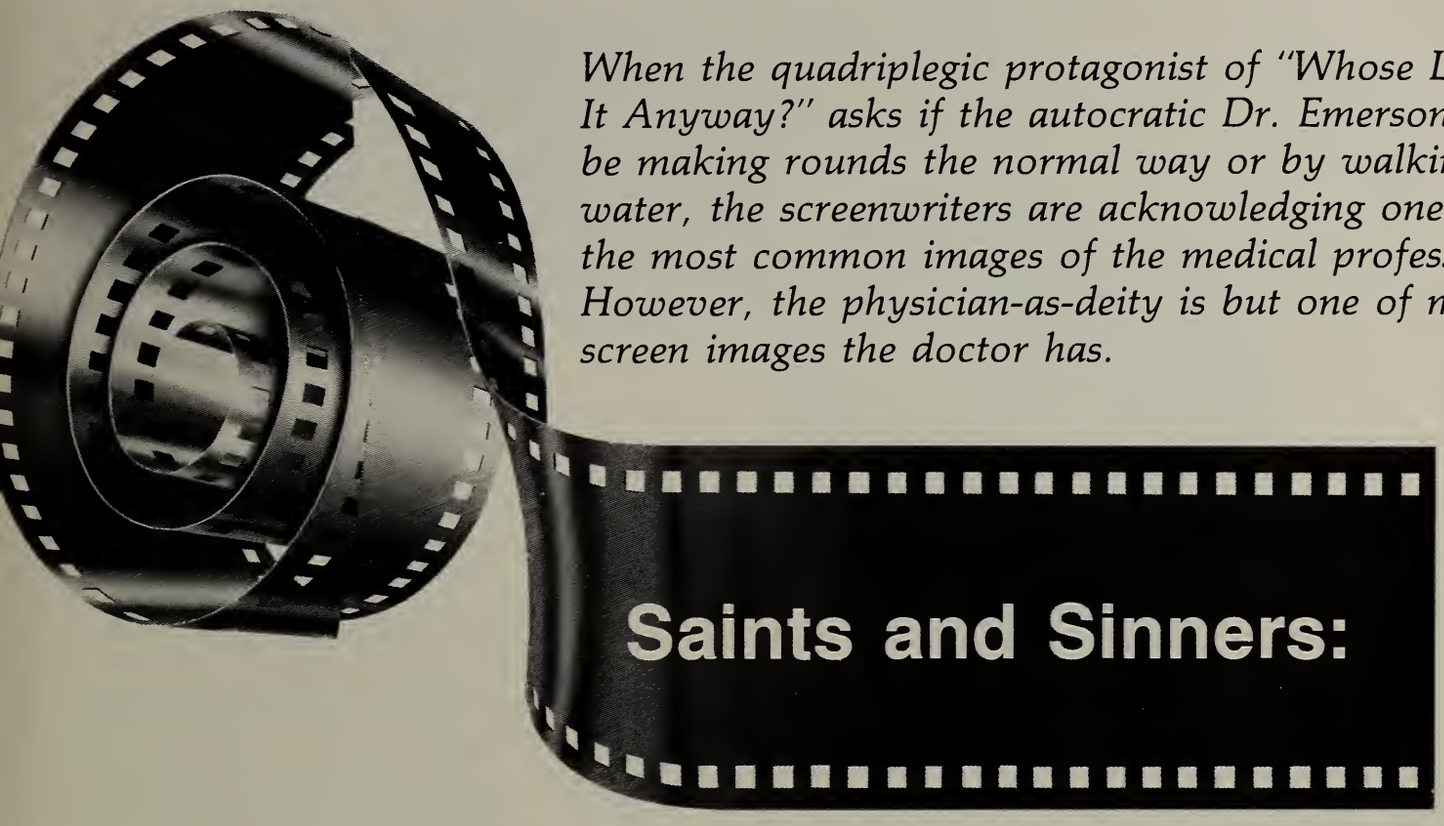
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When the quadriplegic protagonist of "Whose Life Is It Anyway?" asks if the autocratic Dr. Emerson will be making rounds the normal way or by walking on water, the screenwriters are acknowledging one of the most common images of the medical profession. However, the physician-as-deity is but one of many screen images the doctor has.

Saints and Sinners:

Images of the Medical Profession in the Movies

By Richard Shale

A man comes into this hospital in perfect health, and in the space of one week we chop out one kidney, damage another, send him into coma, and damn near kill him.

You know, Brubaker, last night I sat in my hotel room reviewing the shambles of my life and contemplating suicide. But I said, "No, Bock, no don't do it. You're a doctor. You're a healer. You are the chief of medicine in one of the great hospitals of the world. You are a necessary person. Your life is meaningful."

George C. Scott in "The Hospital"

Anyone who attends movies regularly or takes the trouble to explore Hollywood's past soon becomes aware of the astonishing frequency with which doctors have appeared on the screen. In the past few years we have seen Judd Hirsch's Oscar-nominated performance as a caring, sensitive psychiatrist in "Ordinary People" (1980) and Michael Caine's equally gripping portrayal of a psychiatrist turned psychotic murderer in "Dressed To Kill" (1980). "The Elephant Man" (1980) showed us a compassionate Victorian doctor caught between legitimate study and the exploitation of his patient. "Whose Life Is It Anyway?" (1981) examined the right-to-die issue in dramatic terms, while "Young Doctors In Love" (1982) was an amiable spoof of Hollywood's depiction of physicians.

"The Hospital" (1971), a masterful black comedy directed by Arthur Hiller from Paddy Chayefsky's Oscar-winning script, was a landmark in the long history of movies about the medical profession. Its protagonist, Dr. Herbert Bock, played by George C. Scott, was overworked, irascible, brilliant, alcoholic, intermittently impotent, suicidal, and dedicated to his profession — in short, an Everyman figure in the age of anxiety.

The film's hospital setting represented, as one character put it, "the whole madhouse of our times," a theme repeated in the unjustly ignored "Britannia Hospital" (1982), a British black comedy which used the paralyzing chaos of a five hundred year old hospital as a metaphor for England or even, as *Newsweek*

Physicians should familiarize themselves with the screen image of their profession and remember that the public's perception of the medical community is more likely to be formed by the fictional creations of Hollywood than by encounters with real doctors.

suggested, "the entire Western world."

But it is not only the films about the medical profession that have contributed to the omnipresence of the doctor on the screen; the physician's versatility as a supporting player has, if anything, been equally significant in forming an image in the public's mind. "E.T. The Extra-Terrestrial" (1982), for example, has little to do with medicine, yet its climactic scene features a team of doctors frantically trying to save E.T.'s life. Paul Newman in "The Verdict" (1982) plays a lawyer, not a doctor, but the key trial scene focuses on a case of medical malpractice. The "Star Trek" films present Dr. "Bones" McCoy as a valuable crew member on the *Enterprise.*

The business of healing, of saving lives — either by diagnosing and curing a disease or by performing surgery — is a natural subject for drama and suspense, but there are additional reasons why filmmakers have focused so frequently on the medical profession. One is an economic truism which reflects Hollywood's traditional reluctance to take risks. Historically, films about doctors have done well at the box office, so it is natural for Hollywood to keep imitating past successes.

It also helps that the medical profession is easily understood. A filmmaker need not spend valuable screen time explaining what a doctor does, as he might be required to if, for example, the protagonist were a biophysicist. More importantly, doctors are generally well known in the community which makes it easier for the screenwriter to introduce them to other characters.

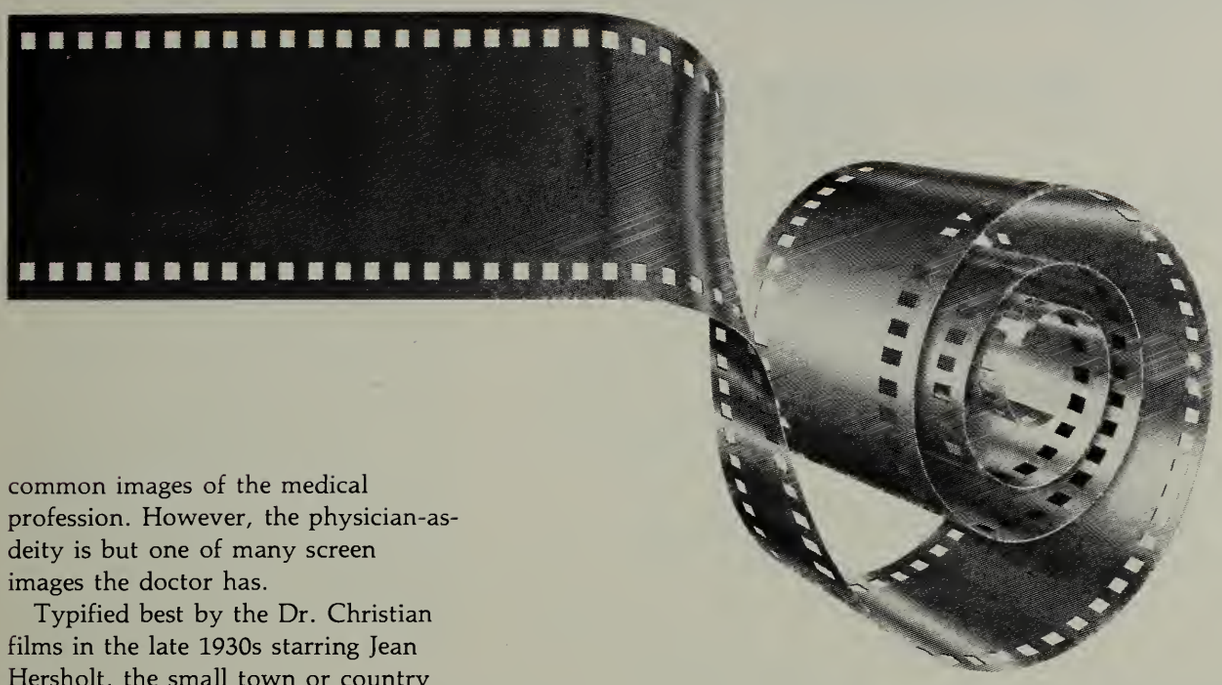
Finally, and perhaps most significantly, the doctor, unlike virtually all other professions, is a character limited to no particular time period or genre. Equally at home from the age of Hippocrates to the present, the doctor has become a familiar figure in the comedy, horror, western, science fiction, detective, or war film. All movie genres, save perhaps the musical, offer a history of images of the medical profession. (And Bob Fosse's 1981 quasi-autobiography "All That Jazz" proved that even musicals could build important scenes around medical care.)

Unrestricted by either genre or time period, the Hollywood screenwriter has embraced the medical profession with enthusiasm but not always with a deep regard for accuracy.

Amnesia, for example, arguably Hollywood's favorite malady, appears far more frequently on the screen than its occurrence in daily life would warrant. Franklin Fearing, in a January 1946 *Hollywood Quarterly* article on psychiatric films such as Alfred Hitchcock's "Spellbound" (1945), took screenwriters to task, noting, "The Hollywood Studio spends much money to be certain that the paving stones in the medieval courtyard or the costume of the heroine are historically correct. Surely," he pleads, "authenticity with respect to the structure of human personality and human motivations is as important as authenticity of settings." This quest for greater accuracy led the AMA in the mid 1950s to establish an advisory committee to assist filmmakers and to promote a positive, accurate image of physicians.

Through the editing process, film has always demonstrated an ability to play with time. In the medical melodramas, time is frequently altered in favor of the story line. Time of diagnosis and time of recovery are most often unreliably presented in order to enhance a dramatic point. In "Spellbound," psychiatrist Ingrid Bergman's kindly old mentor, played by Michael Chekhov, scoffs at the notion of a quick recovery and predicts that six months or more may be necessary to plumb the depths of Gregory Peck's disturbed amnesiac mind. But he has reckoned without the power of love which, as any moviegoer knows, is powerful medicine indeed. Bergman pleads for a few days, and through her devotion, sacrifice, and love is able to make a breakthrough which had previously eluded her. The fact that she had to fall in love with her patient in order to cure him is neatly overlooked. Such a practice may be ethically unsound, but it makes a popular story line.

When the quadriplegic protagonist of "Whose Life Is It Anyway?" asks if the autocratic Dr. Emerson will be making rounds the normal way or by walking on water, the screenwriters are acknowledging one of the most



common images of the medical profession. However, the physician-as-deity is but one of many screen images the doctor has.

Typified best by the Dr. Christian films in the late 1930s starring Jean Hersholt, the small town or country doctor enjoyed a popularity in the first half of this century which has waned in recent decades. The country doctor was invariably a plain spoken, older general practitioner more interested in patients than payments. By the 1970s this kindly image had evolved, on TV at least, into Dr. Marcus Welby, but the big screen had begun to favor a more unscale, hip physician — the Park Avenue or Beverly Hills specialist. In this rarefied milieu, the patients were generally rich and sexy, and so was the doctor.

The image of the doctor-scientist presents a duality. Its positive side has given us films about dedicated researchers such as "The Story of Louis Pasteur" (1936), "Dr. Ehrlich's Magic Bullet" (1940), and "Madame Curie" (1943), yet it is the dark side which has the richer cinematic history.

Doctors Frankenstein, Jekyll, and Moreau, to name just three, have given audiences memorable portraits of the doctor as mad scientist. So popular are these demented doctors that the Frankenstein and Jekyll and Hyde stories have each been filmed at least twenty times. Dr. Irving Schneider, writing in the *American Journal of Psychiatry* (134:6:616, June 1977) reminds us that "the first prominent horror film — 'The Cabinet of Dr. Caligari' — is also the first prominent film about a psychiatrist."

The comic quack has been a stock figure in film from the silent era to the present. Harold Lloyd, W.C. Fields, Groucho Marx, and Peter Sellers all played doctors of dubious ability. Woody Allen's "Everything You Always Wanted To Know About Sex* (*But Were Afraid to Ask)" (1972) offered a variety of episodes satirizing Dr. David Reuben's bestseller. Mel Brooks made fun of psychiatrists in "High Anxiety" (1977).

Blake Edwards' biting satire of Hollywood, "S.O.B." (1981), will be remembered not only for Julie Andrews baring her breasts but for Robert Preston's amusing portrayal of Dr. Irving Finegarten, a "Dr. Feelgood" whose pills and syringes accommodated every mood of his show business patients.

The drunken or addicted professional, a stock figure which can appear in all genres, is best exemplified by Thomas Mitchell's Academy Award winning performance as the alcoholic Doc Boone in the classic western "Stagecoach" (1939).

Many a medical melodrama has been constructed around the relationship between a younger and older doctor. The brilliant medical student or the idealistic intern clashes with an older tradition-minded foe or is taken under the wing of a kindly old mentor. The formula was indelibly set in the 1930s when novelist Max Brand's Dr. Kildare made his screen debut.

"Interns Can't Take Money" (1937) starring Joel McCrea was the first Kildare film, but the series did not take shape until the following year when Lew Ayres assumed the title role in "Young Doctor Kildare." Lionel Barrymore co-starred as the crusty Dr. Gillespie. Ayres was replaced in the mid forties, but the series continued until 1947.

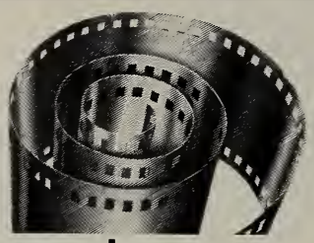
Doctors, of course, are not the only members of the medical profession to be victimized by distortion and stereotyping. Most hospital administrators have been treated rudely by Hollywood screenwriters, though few have been painted so malevolently as Richard Widmark in "Coma" (1978).

Nurses have probably suffered more than doctors at the hands of screenwriters, for, according to Hollywood, they seem to exist only as militant harridans or as sex objects. Indeed, when it comes to stereotyped

for sexual promiscuity, only stewardesses appear to rival nurses in this regard.

Perhaps the most indelible portrait of a nurse ever brought to the screen was Louise Fletcher's Oscar-winning performance as Nurse Ratched in "One Flew Over the Cuckoo's Nest" (1975). Her cool civility masked a streak of insensitivity and dictatorial power in her battle of wills with the patients. In a lighter vein, Cloris Leachman's militant Nurse Diesel in "High Anxiety" helped perpetuate the Nurse-as-Nazi in a more comic way.

However, not all films about nurses have resulted in one-dimensional portraits. "Nurse Edith Cavell" (1939) and "Sister Kenny" (1946) offered screen biographies of real nurses, and Ingmar Bergman's Swedish masterpiece "Persona" (1966) presented a psychological duel between a nurse and patient in which the roles began to reverse. In "The World According to Garp" (1982), the eccentric Jenny Fields, played by Glenn Close, showed a positive image of caring.



Nurses have probably suffered more than doctors at the hands of screenwriters . . .

Despite ongoing campaigns for greater accuracy and occasional films which present well rounded, undistorted characters, it is unlikely that Hollywood will soon break away from an 80-year-old tradition of sensationalism and oversimplification and begin to offer a realistic view of the medical profession. In all likelihood, people will continue to see a doctor more frequently not in the well-lighted surroundings of his or her office but in the darkness of a movie theater. Physicians should familiarize themselves with the screen image of their profession and remember that the public's perception of the medical community is more likely to be formed by the fictional creations of Hollywood than by encounters with



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Louise Fletcher as Nurse Ratched with Jack Nicholson in "One Flew Over the Cuckoo's Nest."

real doctors.

Richard Shale is an Assistant Professor of English at Youngstown State University, and teaches an annual course on the image of the medical profession in the movies at the Northeastern Ohio Universities College of Medicine.

Author's Note:

No book-length study on the image of the medical profession in the movies exists, but two excellent essays offer a helpful starting point for those wishing to explore the subject further. "Medicine and the Physician in Popular Culture" by Anne Hudson Jones, published in *The Handbook of American Popular Culture, Volume III* (Inge, M. Thomas, ed., Westport, CT: Greenwood Press, 1981), is an extensive bibliographic essay which, as the title implies, covers far more than film. "The Doctor On the Screen," a chapter in Jack Spears' *Hollywood: The Golden Era* (NY: Barnes, 1971), provides a comprehensive catalog of titles in a historical context.

Franklin Fearing's "The Screen Discovers Psychiatry" in the January 1946 *Hollywood Quarterly* and Laurence Kubie's "Psychiatry and the Films" in the January 1947 issue of the same periodical were early attempts to examine the screen image of psychiatrists. A more recent and much more comprehensive essay on the subject is Dr. Irving Schneider's "Images of the Mind: Psychiatry in the Commercial Film" published in the June 1977 *American Journal of Psychiatry.* Linda Martin's January 25, 1981 *New York Times* article "The Psychiatrist in Today's Movies: He's Everywhere and in Deep Trouble" nicely updates Schneider's essay.

Finally, Leslie Halliwell's *Filmgoer's Companion* (NY: Scribner, 1980), an invaluable encyclopedic reference book, contains entries on doctors, nurses, dentists, psychology, amnesia, and hospitals, each followed by a representative list of films.

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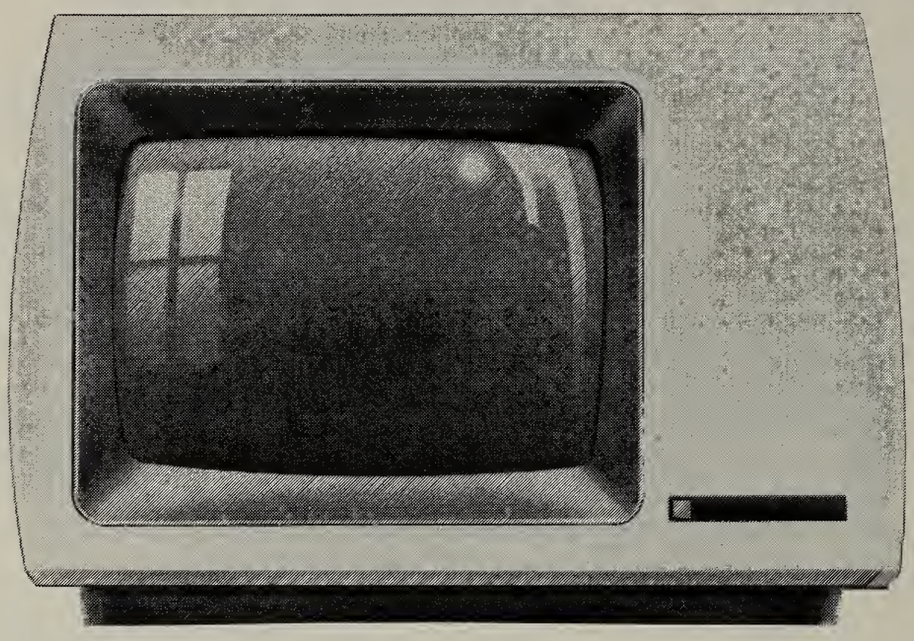
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Physicians on Television



The Small Screen's Larger-than-Life Image

By Karen S. Edwards

Of all forms the media takes . . . of all the images that are presented in newspapers, magazines, books and in darkened movie houses, probably none has quite the impact on the American public that television does.

Its power to influence people is felt in everything from political elections to the products people pull off grocery-store shelves . . . and considering television's relatively long medical history, it shouldn't come as too much of a surprise that the image many people have of the medical profession, itself, comes from what they see on their living room sets.

"During the '50s and '60s, doctors were portrayed as perfect. They were these great people who could not only correctly diagnose your disease — which was usually something rare — but they could fix up your personal life as well," says Jeff Borden, who, for the past four years has served as the radio/television reporter for the *Columbus Dispatch*. Borden admits, however, to watching a lot of television before assuming the duties that now requires some 12-15 hours of television viewing a week.

"I'm not one of those TV critics who brags about not watching TV," he says. "I really do watch it — and I used to watch it as a child."

In reminiscing about the medical heroes of the '50s and '60s, Borden says Ben Casey was the closest thing medicine ever had to a tough guy — someone who wasn't quite as perfect as others of his genre.

"But he still had those exceptional humanistic qualities his colleagues had," Borden says — and it was rare when the good doctor would miss a call.

"Colleagues on the show — usually guest stars — might be allowed to foul up a case, but never the hero."

That philosophy began to change somewhat during the '70s.

"During the '70s, 'Colombo' (a detective drama starring Peter Falk) presented a doctor as a villian on one of its shows. It was at that point that television began to paint the profession in a less than perfect light."

Then, along came "M*A*S*H," the long-running series starring Alan Alda, and suddenly, the image of the physician on television seemed to

reverse itself entirely.

"Now we began to see doctors who had human vices — they drank, they chased women — their surgical gowns weren't clean and white like those of their '50s and '60s predecessors. They even lost cases," something which was almost unheard of prior to this.

"Do you realize that during the 11 years Perry Mason was on TV, he only lost seven cases?" Borden asks, illustrating TV's general reluctance to paint their heroes as losers . . . even occasional ones.

But despite the new dimension "M*A*S*H" added to TV physicians, "the program still managed to preserve the medical image," Borden says. "The character's actions were always tempered by the madness of war. Underneath their antics, you could see that these were genuine, caring, humanity-driven doctors and nurses who indulged in these vices because of their set of circumstances."

The show's Frank Burns character was a first for television. Doctors — at least guest stars — may have been bunglers in the past, but not until "M*A*S*H's" Frank Burns were they depicted as being associated with money, country-clubs and other luxuries.

"He was definitely the odd-man out — the character the other characters could poke fun at," says Borden, adding that such a character is often a common device on television shows — as witness the Ted Baxter character on the old "Mary Tyler Moore Show"; Herb Tarlak on "WKRP In Cincinnati"; and, to a certain extent, the Howard Hunter character on "Hill Street Blues."

All of this, of course, has lead the way to the '80s, and the current crop of television doctors — some of whom are a far cry from the way doctors looked, thought and acted twenty years ago.

"St. Elsewhere" perhaps, best exemplifies this difference.

"We know that the show is not really realistic with regard to time-frame, and other matters, but an atmosphere of realism has been added to this show which makes it more believable than most," says Borden.

Except for a show called "Life-Line" which premiered in 1979 on NBC and has been sporadically repeated on PBS stations since, medical shows may never be as realistic as some physicians might have them be.

" 'Life-Line' was an exception to television medical shows. It was more like a documentary in its approach — featuring real-life medical crises. The shows were stark and featured some graphic footage, but they were emotional as well."

Despite the new dimension "M*A*S*H" added to TV physicians, the program still managed to preserve the medical image. The character's actions were always tempered by the madness of war.

The program didn't last long.

"Most of us want escapist entertainment, and obviously this wasn't it," says Borden.

But escapist entertainment has its drawbacks.

"Hollywood has to temper realism with dramatic theme. That's the vise in which writers find themselves," Borden explains. "They need to be fair, but they also need to establish plot devices, so they can't always be realistic — especially with regard to time. Things happen much faster in television than they do in real-life. For example, there was an episode of 'St. Elsewhere' last year in which a heart transplant patient was waiting for a heart. On the show, she waited something like eleven weeks when, in actuality, she would probably have waited at least thirty weeks for a heart to be donated.

"Yet, when we watch TV we allow for that telescoping of time — at least, I hope we do. Usually people recognize that things have to move along."

Realism, too, has to take a back seat to dramatic elements.

"All dramatic shows have to have interaction between characters, and that's one reason why medical shows are so popular," Borden explains. "There is a chance each week for the doctor to get involved with different characters, different cases and different patients."

In fact, most television programs are based on what Borden describes as TV's Holy Trinity — lawyers, cops and doctors.

"All three of these professions deal constantly with people, and all three have the capacity of dealing with life-and-death situations. You're not going to find people who are interested in watching a show about an electrical engineer or a carpet cleaner. The potential for high drama just isn't there. Doctors, cops and lawyers are a durable genre. They've proven themselves to be interesting to a viewing public."

Not all medical shows today are making the same bow to realism that "St. Elsewhere" is, however.

" 'St. Elsewhere' gives us an assortment of characters. We have the physician as father figure; the cold but brilliant surgeon whom you would want to have operate on you but not show up at your bedside; and the young, idealistic resident. But to balance things out, we have the Peter White character who is really something of a landmark in prime-

time TV."

Primarily because the character, who is painted in such a negative light on the shows, is not only a resident — but one of the program's continuing performers.

"Here is a guy who has had marital problems, drug problems, and is a rapist, yet he's shown to be a good physician — *and*, so far, at least he continues with the show."

He is certainly not a character that would surface on another of today's medical shows — "Trapper John, MD" — unless, of course, it were in a guest appearance.

" 'Trapper John' and 'AfterMASH' are more like the shows we used to watch. The same values are there — the driven physician with noble purpose. You can bet when they wheel their patients into the operating room they'll wheel them back out."

Which, again, is unlike "St. Elsewhere," where the patient is as likely as not to die on the operating table.

"My parents finally gave up watching 'St. Elsewhere,' " says Borden. "They would follow the story line for weeks and really get involved with the characters only to watch them die. They told me they were tired of going to bed depressed."

Small wonder, then, that "Trapper John" is doing much better in the ratings.

"A lot of people prefer happy endings," says Borden. "They are more comfortable with a show like 'T.J. Hooker' than 'Hill Street Blues.'

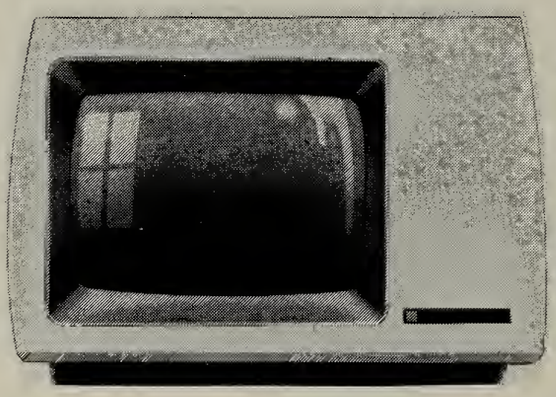
"Personally," he adds, "I prefer it when characters are allowed to make mistakes. Their triumphs appear that much more compelling if you've had the opportunity to also witness some of their failures."

It is an opinion that is apparently shared by many of television's more educated viewers.

"It's one reason shows like 'St. Elsewhere' and 'Cheers' and 'Hill Street Blues' can continue to stay on despite their poor ratings," says Borden.

These shows draw a more professional, affluent viewership — the kind advertisers like to attract.

"The guy with a car to sell would rather be attracting a small young, urban professional group which has the money to spend, than a huge group of blue-collar factory workers," explains Borden.



Most television programs are based on TV's Holy Trinity — lawyers, cops and doctors. All three deal constantly with people, and all three have the capacity of dealing with life-and-death situations.

As for the new crop of TV medicos, Borden has differing opinions.

"I'm not sure why the Bill Cosby character is an ob-gyn," he says "except that Bill Cosby, himself, is a very well-educated man, and I'm sure he is concerned with creating a potent professional image for blacks. He probably chose the medical profession because that is one of the most powerful professional images there is.

"But I don't see the medical side entering the picture much. This show will be about family relationships" — possibly because medical shows have never really succeeded well as comedies.

" 'Doc,' a medical-comedy starring Barnard Hughes didn't last long, and even the best 'M*A*S*H' episodes were ones that didn't involve a lot of comedy," says Borden.

This year's new "E.R.," starring Elliott Gould is what Borden describes as an "uneasy blend of comedy and drama," and, given the few shows he has seen, he is not sure how it will work out.

"Jessie," the new show about a police psychiatrist is, he feels a more clear-cut case.

"The show doesn't know what it wants to be, so it ends up being absurd. It simply has no roots in reality. Jessie is depicted as a cross between Sherlock Holmes and God."

But last year's medical shows, says Borden, were even worse.

"Last year, we had 'Trauma Center,' which was medicine's bow to the special effects department . . . and 'Cutter to Houston.' That one was awful. There was one character on it who had supposedly been in trouble with the State Medical Board for selling drugs, and, instead of having his license pulled, he was sent to this tiny emergency room which existed somewhere in the Texas backcountry. Apparently this was his punishment, and the theory was if he were placed in this godforsaken area, he couldn't get into any more trouble trafficking drugs. How absurd. The show was yanked after five episodes."

Both shows, however, shared the same old-fashioned approach to medicine that we saw from "Dr. Kildare," "Marcus Welby," and are currently viewing on "Trapper John."

"I see shows like 'Hill Street' and

'St. Elsewhere' as post-Watergate shows. They could only have come on TV after something like a Watergate occurred. But, lately, under Reagan, we've seen conservatism coming back into vogue, so we may begin to see a return of more of the traditional types of medical shows in the future."

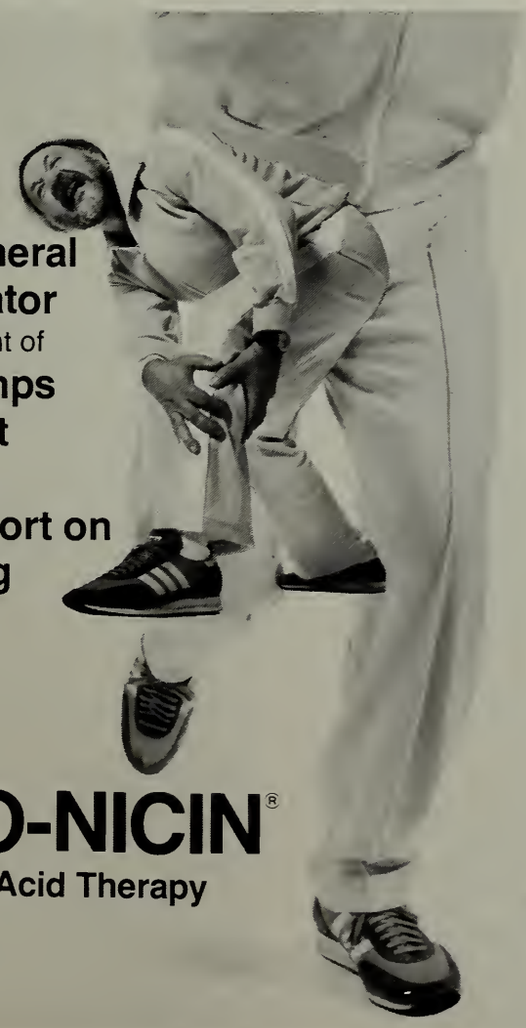
Borden is confident that no matter what form medical shows may take in the future, however, the image of the physician as a high-principled, highly-skilled professional will be preserved.

"Television has been very kind to physicians — both past and present. They have come out of thirty years of television smelling like a rose," he asserts.

"I prefer it when characters are allowed to make mistakes. Their triumphs appear that much more compelling if you've had the opportunity to also witness some of their failures.

"In fact, the biggest problem the real-life physician may have with his larger-than-life television image," concludes Borden, "is trying to live up to it." **OSMA**

Karen S. Edwards is the Executive Editor of the Ohio State Medical Journal.



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While physicians may feel they are taking it on the chin where the national media is concerned, a week-long study revealed nothing in the state's news publications to indicate that the press is out to disrobe the physician of his or her clean white jacket.

Physicians in Print

What the Ohio Print Media Are Saying about Today's Doctors

By Susan Porter

Pick up almost any Ohio newspaper on any day of the week and somewhere within its pages you'll come across the subject of medicine — be it a front-page story on a new scientific breakthrough, a series of articles on rising health-care costs, a feature story on a common or not-so-common disorder, a health care column by a local practitioner or simply the announcement of a new health care facility or practice. And, more than likely, one or more physicians will be named or quoted within the context of each of those stories.

Today, more than ever before, health care news is big news. With the overall aging of the population has come an increased interest in lifestyles, diet, exercise and disease prevention, as well as new means of treating disorders and diseases. And it is the physician, as the primary authority on health care, who is often quoted.

Yet, increasingly, the diverse and sometimes divergent opinions of business leaders, politicians, insurance carriers and allied health care professionals are slipping into the context of these stories — especially those related to the more complicated and controversial socioeconomic aspects of health care. And some physicians are fearing that "bad press" is beginning to dirty the once spotlessly-white image of the physician.

"Every time you turn around these days the media seem to be taking another potshot at doctors," says a recent issue of *Medical Economics* magazine. "The point is that just about every practicing physician in the country these days is being affected by 'bad press' in one way or another."

Are Ohio newspapers contributing to this dilemma as well? In order to find out, the *OSMA Journal* decided to look at a typical week's offerings from the state's news publications and see just why and how Ohio doctors names find their way into the news — and, subsequently, what kind of light is being shed on the medical profession.

As subscribers to the Ohio News Bureau, Inc., a newspaper clipping service which reviews all of the state's publications — including 95 dailies, 375 weeklies and over 200 trade journals — *The Journal* had access to news stories printed in every part of the state. Due to *The Journal's* November deadlines and the time delays in receiving clippings from the News Bureau, we chose the week of Saturday, September 9 through Sunday, September 15 as the most

current week to analyze.

What We Found

Our week-long review showed that physicians are portrayed in the media wearing a number of hats: from business people and authority figures, to scientists and educators — as well as just plain citizens.

Like any individual, they also find themselves the subjects of "hard" news stories or current events topics. One example that week was the story of an Oak Harbor physician — also an amateur stunt pilot — who crash landed his bi-plane into the Portage River, just off the sixth hole of the Oak Harbor Golf Course. The story, which appeared in the September 9 issue of the *Sandusky Register* (circ. 25,850), detailed how the doctor was heroically saved by several golfer-rescuers who waded into three-feet of water, prior to the arrival of the St. Vincent Life Flight emergency crew.

Unlike most citizens, however, the occupation of a physician is, generally, readily apparent in a news story. According to the United Press International stylebook used by most news publications, the title "Dr." is used almost exclusively before the name of a physician, as "the public often identifies 'Dr.' only with physicians." Thus, while a corporate executive, teacher, attorney or secretary may never be identified as such in a news story, a physician — by virtue of his or her title alone — will always be known first and foremost as a physician.

He or she will also be viewed, however, in other roles, as the following analysis reveals. Perhaps it is not so much *how* physicians are being portrayed in the media these days, but *what* it is that they're doing that is considered newsworthy that is giving the public the image it has of today's doctor.

The Physician As Businessman

It has been said the practice of medicine is quickly becoming the business of medicine, and if Ohio

A sample of medical clippings from Ohio newspapers.

Paramedics' C

BY PAUL FURIGA
Enquirer Reporter

On the morning of April 11, Betty Lichtenfels lay on the floor of her home as two Cincinnati paramedics bent over her, trying to start her failed heart.

Katherine Ryan, who lived with Mrs. Lichtenfels, stood near-by.

After four injections, cardi- pulmonary resuscitation a- of instruments to woman's air pass- Mark Brow- decide- Univer revived April 20.

The de ty was a not like. Wh had been stricken Mr Ryan had call Mrs. Lichtenfe

AS GUSTIN elephone, Mrs. ne two parame octor wanted lo had had tw acks, to go to l where Gustin Brown and L. an to Univ telling Mrs.

to her recollect Deaconess was have the right e Months afte April 20 death, daughter, Kar 12-year employ have contin- that d-

Campus Currents

Mark Stephen Nash, son of Mr. and Mrs. Herbert Nash of Beachwood has been named to the faculty of the Departments of Neuro- -ical Surgery, Ortho- -abilitation of Miami Toledo. Dr. Nash received his Doctor of Philosophy degrees in Exercise Physiology and Clinical Anatomy. He will serve as Director of the Clinical Neurostimulation Laboratories, Project Administ- -rator for the South Florida Spinal Cord Director

Doctor Seeks To Reach Those With Lung Problems

Since becoming Good Samaritan Medical Center's medical director of the Cardio-Pulmonary Department in late June, Dr. Paul Knight has taken active steps to reach cardio-pulmonary and black lung afflicted persons.

Lung programs are designed to meet the needs of the large number of miners in the area. According to Knight, many miners would not receive adequate care if this pro- exist

One of the most conce-

Medical crisis response data available to groups

According to Dr. Joseph Smith, medical director of the emergency department of the Chagrin Valley Medical Center, one of the public's most specific health care conce- is how to respond to crisis.

Smith is mu-

er training in emergenc- well as the new and mobil-

e as tics

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Oxford Obstetrics Opening Satellite Office In Eaton

Oxford Obstetrics and Gynecology announce the opening of their new office at 200 North Barron on Sept. 17. The office will be open daily from 9 a.m. until 5 p.m. The telephone number is 456-7164.

Doctors Garvin H. McClain, E. C. Wisenmayer, and John J. Farinacci

are extending their obstetrical and gynecological services to include gynecologic microsurgery and laser therapy in addition to their staffing of the Preble County prenatal clinic

Hospital services will continue t provided by Oxford McCullough-Hyde Memor hospital which has been a pio and leader in Ohio for fa centered maternity care.

newspaper stories are any indication, there is definitely some validity to the statement. By far, news items related to business enterprises involving physicians outnumbered every other category.

Most of the business news where physicians' names were mentioned revolved around proposals for the opening of new clinics, practices, urgent care centers, hospital wings and other types of health care facilities. Some of these projects were not without controversy, and a number of articles pointed out, some confusion exists in the public mind regarding the status of various new health care facilities.

For example, an article, titled "New Medical Center Hopes to Offer Patients a Choice," (*Forest Hills Journal*, Cincinnati, weekly circ. 5,100), discusses "a bit of controversy about having two major medical facilities within a couple of blocks of each other," explaining that two new health care centers were being developed concurrently in the same area — one by a hospital and the other by a physician. "At least one person has approached authorities, asking if the new (physician-owned) facility will be a large, urgent-care center," the article states. "Others have wondered if it will be a hospital . . . the new facility will be neither . . ."

Health care competition was also a background issue raised with the opening of a new free-standing ambulatory care center as reported in the September 13 issue of the *Sun-Star* in Strongsville/North Royalton (weekly circ. 3,700). The center was being opened by a group of emergency medicine specialists in conjunction with a local hospital. The lengthy article, which appeared under inch-tall headlines, quotes a hospital spokesman as saying the center will not compete with a wellness center which will be operated by a Cleveland-based hospital.

Among other new health care facilities involving physicians mentioned in Ohio newspapers that week were the opening of a well-child clinic, a new hospital wing, and a new office of ob/gyns.

Physicians' names also were listed in connection with a $1.5 million donation to Children's Hospital in Cincinnati by Nationwide Insurance, the operation of a new sports medicine clinic in the Cleveland area, the opening of a new dermatology clinic in Portsmouth, and the opening of a new pulmonary medicine practice in Alliance.

The Physician As Authority Figure

Ohio physicians also were commonly quoted as authority figures in newspapers the week of September 9-15, particularly on topics of a clinical and scientific nature. While occasionally a major headline story appeared reporting a medical innovation or break through, most of the news in this category revolved around special programs or seminars being conducted by physicians, groups or organizations. Weekly newspapers, especially, commonly publicized these events, which not only brought attention to the physician's name and practice, but also showed him or her as someone interested in community service and willing to help inform the public.

Physicians are portrayed in the media wearing a number of hats: from business people and authority figures, to scientists and educators — as well as just plain citizens.

Hard news on scientific breakthroughs involving Ohio physicians was reported only in a few instances that week and was chiefly found in the larger metropolitan papers. For example, Dr. John DeFazio, a gynecologist who heads the in vitro baby program at University Hospitals in Cleveland, was interviewed in connection with an experiment using a small insulin pump to deliver hormones to women with fertility problems (*Cleveland Plain Dealer*, September 9).

In another case, Dr. Robert Heath, an orthopedic surgeon and the medical director of Pearlman Orthopedic Tissue in Cincinnati, was quoted in connection with recent advances in bone and soft tissue transplantation (*Cincinnati Enquirer*, September 15).

A front-page banner headline story in the *Columbus Dispatch* Tuesday, September 11, discussed the efforts of 20 Central Ohio urologists to buy a $2 million extracorporeal shock wave lithotripter. If successful, Columbus would be the first city in Ohio and the seventh in the nation to obtain the innovative kidney stone disintegrating machine, the article said.

And the *Cleveland Jewish News* (weekly circ. 15,700) reported that week on the efforts of physicians at Mt. Sinai Medical Center to correct a congenital urinary tract deformity on a 16-year-old Moroccan youth.

In addition, a Bowling Green physician was asked to comment that week on a reported outbreak of hepatitis among employees of a restaurant in the university area (*BGSU* student news).

The Physician As A Good Citizen

In other types of newspaper stories, physicians were portrayed more overtly as good citizens — as the recipients of awards, as the initiators of public action, and as volunteers in

community service. Often these stories took the form of short announcements of their accomplishments or successes, but occasionally they were developed into more lengthy, human-interest or feature stories, allowing the physician to be seen or heard as an individual, as well as a professional.

For example, Dr. Paul Beaver, the team physician for the Leetonia High School football team for almost 60 years, found his name and photo in the September 15 *Morning Journal* (Lisbon, circ. 15,300) when he was awarded a gold-plated lifetime pass for free admission to all of the school's activities. Dr. Beaver, age 87, was quoted in the article as vowing to serve the community for yet another 13 years, "When I'll be 100."

In another instance, a Middletown physician received considerable attention in the *Middletown Journal* (circ. 26,700) when he decided at the age of 46 to relocate to Fort Royal, Virginia. "People historically have always thought physicians never move," Dr. Sizer is quoted as saying.

Emergency room physicians, in general, were praised as a group in several articles revolving around the coming of Emergency Medicine Week (September 16-22). "There's an unsung hero in local hospital emergency rooms, a physician who daily serves the lives of many — the emergency department physician . . ." reads the beginning of one such story in *The Journal Herald* (Jackson, weekly circ. 10,000).

Other physicians were mentioned in newspaper columns throughout Ohio that week for their interest and work in respiratory diseases and mental health, for serving as advisors to a county medical assistants organization, for participating in teleconferences, for earning hospital privileges and for a variety of other professional and public honors.

The Physician As Defendant

Doctors' names also appeared in the news of the week of September 9-15 in connection with court cases, including several pending malpractice suits. In Clinton County, for instance, two Wilmington physicians were being sued in the Court of Common Pleas in connection with the death of an infant at childbirth, according to a story in the *Wilmington News Journal*, circ. 7,300).

Three physicians and the Geauga Community Hospital were listed as defendants in the *News Herald* (Willoughby, circ. 31,300) in a case where a woman claimed she underwent a cesarean section without being properly anesthetized.

Both *The Journal News* (Hamilton, circ. 30,000) and the *Middletown Journal* (circ. 26,700) reported on a malpractice suit settled out of court that week involving the Middletown Regional Hospital and several physicians. In this case, a woman claimed her husband died following an adverse reaction to a drug administered at the hospital.

Ohio physicians also were commonly quoted as authority figures in newspapers . . .

Physicians also were quoted in the newspapers for their expert opinions regarding court cases and public or political actions. For example, a Cleveland physician was quoted in the *Sun Press* (Cleveland Heights, circ. 40,500), regarding a lawsuit involving a child suffering from lead poisoning. In another case, a Cincinnati cardiologist appeared before the city's law committee to question a policy requiring emergency squads to report to the nearest hospital when dealing with life-threatening situations *(Cincinnati Enquirer)*.

Conclusions

While the above examples by no means cover all cases where physicians' names were in the news the week of September 9-15, they do provide an overall sampling of how doctors names are increasingly finding their way into the media. And — as is readily apparent — much of this news is generated by physicians, themselves, along with the organizations, associations or institutions with which they are involved.

Even among the most debatable topics, physicians were given a chance in the local media to explain their side of the issue.

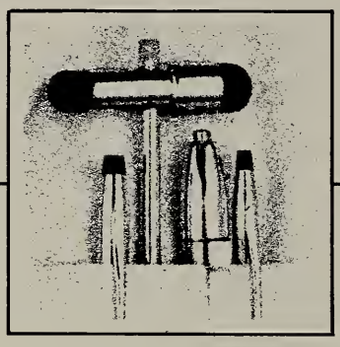
Perhaps the most controversial subject to come into the news that week was a series of articles on health care costs which appeared in the *Canton Repository* (circ. 65,600). And one of these articles, titled "Citizens, too, can help lower health-care bills," was delivered entirely from the physician's point of view on the subject, pointing out how first-dollar insurance coverage, defensive medicine, and poor health habits are all helping to drive up the cost.

Thus, while physicians may feel they are taking it on the chin where the national media is concerned, there was nothing in the state's news publications the week of September 9-15 to indicate that the press is out to disrobe the physician of his or her clean white jacket and spotless reputation.

On the contrary, the local news media seemed more than willing to portray today's physician in the traditionally positive light as authority figure and community servant, to explain his or her role in business ventures, to devote considerable space to medicine's views on rising health care costs, and to feature and honor doctors as individuals, as well as professionals. **OSMA**

Susan Porter is the Assistant Editor of the **Ohio State Medical Journal.**

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Communications staff member Doug Evans and former Communications Director Rebecca Doll interview a seminar participant during one of the media training seminars held for Ohio physicians.

OSMA Media Training Seminars: Facing the Camera

By Susan Porter

It's the typical "60 Minutes" ambush. A Mike Wallace-type reporter, microphone in hand, is crouched behind a hospital delivery truck. Behind him is a husky, ill-dressed cameraman, dozing against a wheel. It is 5 a.m. and the early morning shift is just beginning to arrive at St. Samantha's Hospital.

Suddenly, a small black car pulls into the parking lot. A tall bearded man gets out of the car, a briefcase in one hand, a white jacket in the other. "That's our man!" the reporter cries, nearly knocking over the cameraman. "Let's go."

Within seconds, the unsuspecting physician is surrounded by lights — the camera and microphone are thrust into his face. "Doctor, is it true that an elderly patient died in your waiting room yesterday afternoon because you refused to take anymore Medicare patients?"

Most physicians will experience the above scenario only in a nightmare. But for an increasing number of health

care providers, some difficult questions are being posed regarding the practice of medicine — and more than a few are being answered — however nervously — before thousands of viewers and readers.

While a confrontation with a Mike Wallace is enough to unnerve even the most competent, confident physician, contacts with the media aren't necessarily bad, says Rebecca J. Doll, former director of communications at the Ohio State Medical Association (OSMA) and now vice president of Market Group One, a marketing and consulting firm for physicians in Columbus.

In fact, says Doll, the media can be of invaluable assistance in allowing physicians to have *their* side of the health-care-cost story told, particularly today when doctors seem to be under fire from almost every other group.

"Communications is the key to maintaining the support of our constituents — from our legislators to our patients," Doll recently told participants in a series of Media Training Seminars sponsored throughout the state by the OSMA. "The news media can be our most valuable resource," she continues. "Studies show the media have replaced the church, the school and the family as the institution from which people draw their attitudes and beliefs."

Television, in particular, has the power to deliver a message to millions of people in a matter of seconds. Yet it is one of the most difficult mediums in which to be heard, requiring a thorough understanding of why and how the media operate, says Doll.

The purpose of OSMA's media training seminars is to help physicians understand the medium of TV — to teach them to face the camera, rather than to duck or avoid it.

According to Carol Mullinax, the new OSMA communications director who has assisted Doll with the seminars for the past six years, physicians who participate in the seminar are given the chance to appear on camera and to field questions posed by OSMA staff. The questions cover a wide variety of controversial socioeconomic topics, ranging from "medical care for the elderly" and "fraudulent medical degrees" to "communications problems between physicians and patients" and "medical professional liability."

A physician who wishes to get his or her message across to the public through the media must play the game according to the media's rules. *They* own the presses, *they* own the antennas.

Not only does the exercise benefit physicians as individuals; it also aids organized medicine by providing competent spokespersons willing and able to address controversial health care issues from the physician's standpoint. And as Doll points out, it's important that they be prepared, because, "The public judges all doctors by those few most visible ones."

How the Media Work

While journalists proclaim the media's primary purpose is "to protect the people's right to know," says Doll, media outlets such as newspapers, TV and radio stations are, in essence, businesses with a bottom-line goal of making a profit. They do so primarily through the sale of advertising, which determines how much room will be available for news. "The size of your daily newspaper is not determined by how much news occurred that day, but rather by how much advertising was sold that day," Doll points out.

The news that fills in the space or time left by advertising generally covers a variety of topics, from events and issues to personalities and products, says Doll. In general, it focuses on those subjects, issues and viewpoints that will appeal to the broadest audience or readership — and subsequently will sell the most advertising.

Therefore, a physician who wishes to get his or her message across to the public through the media must play the game according to the media's rules, Doll warns. "They own the presses, they own the antennas," she says. "They decide what to print and what to say — and they only do what's good business for them."

Thus, segments aired on the nightly news must not only interest the vast majority of viewers — they also must be understandable to them. Medical terminology or "jargon," therefore; must be eliminated if one hopes to appeal to and get a message across to a TV audience.

It is also important that the physician being interviewed take into account the audience's circumstances, concerns and point of view — and empathize with the viewer. "The average factory worker making $18,000 a year doesn't want to hear about the problems with your overhead or your high malpractice insurance premiums," Doll says. "He's concerned about his own problems — his high medical bills and the quality of the care he's getting. You're not going to win any friends by complaining."

The physician also needs to take into consideration the reporter's needs if he or she wishes to appear — and make a favorable appearance — in the media. "Reporters, like physicians, are professionals and want to be treated as such," Doll points out. "Always return their phone calls promptly, never keep them waiting in your office and never ask to see their stories in advance."

In addition, words like "no comment" should be stricken from the vocabulary of every physician, Doll



Seminar participants have an opportunity to critique each other's on-the-air experience.

says. "If you don't know the answer, refer them to someone who does," she says. "If you don't wish to speak to the issue, explain why — that the issue is in litigation, for instance, and your attorney has advised you against talking about it."

A physician who ignores the needs of the audience or the media does so at his or her own peril. "If you aren't available for comment, someone else will be," Doll points out. "They'll interview the psychologist instead of the psychiatrist — the nurse midwife instead of the Ob/Gyn — and their story will be told, not yours."

Getting Prepared

Once a physician has consented to an interview, the key to its success is to be prepared, says Mullinax. Fortunately, in most cases, reporters don't sneak up from behind their subjects and ask them to comment on controversial topics, such as the example used at the beginning of the story. But, due to the timely nature of a news topic, it may be only a matter of hours or even minutes between a call from a reporter and the actual interview. Thus, preparation actually begins with the first phone call from the reporter, Mullinax says.

"Before you even hang up the phone, find out what subjects are going to be covered in the interview and the format the interview will take," she says. Because most news stories are a reaction to something that has happened, it's important that the physician know just what has occurred and the various connotations of that event. While most reporters won't give the exact questions that are going to be asked in advance, they generally are more than willing to provide the background necessary to make a good interview, because it reflects on the quality of their program as well as the physician's credibility and appearance.

The format of the show on which the interview is to appear is equally important — is it to be included on the evening news or on a locally-produced talk show? Will it be live or taped? Will others be appearing with you on the subject or will you be alone?

Once all of this has been determined, the physician can hang up and begin working on his or her homework. This includes not only gathering the information necessary to adequately cover the topic, but also deciding what angle to take in the presentation.

It is also important to determine, at this point, for whom you'll be speaking, Mullinax says. For example, a physician asked to speak as an individual in private practice might answer questions quite differently than one who is speaking for an organization of physicians such as OSMA. "And if you've agreed to speak for a group, make sure you stick with that group's point of view," she says. "If you don't agree with that point of view, ask someone else to do the interview."

At this point, the physician should develop several "key statements" he or she would like to have voiced on the air. Mullinax calls these SOCO

Remember, an hour after you're on the air, people aren't going to remember what you said, but how you said it. If you get aggressive or lose your cool — that's how you'll be remembered.

Facing the Camera

continued

statements — "Single Overriding Communication Objectives" — that insure that the physician's point of view will be heard in addition to the questions he or she will answer. "SOCO statements are concise, 15 to 20 second statements that can be lifted out and put right into the evening news," Mullinax says. Their brevity and pointedness not only appeal to the film editor who is putting the news show together; they also work well with the majority of audience members who, on the average, have an attention span of 60 seconds or less, Mullinax says.

But researching a topic and preparing key SOCO statements are not enough, according to Mullinax. "It's also important that you anticipate questions in advance — especially negative ones," she says. "You might want to think up the most damaging, negative questions a reporter might ask you and prepare responses to these questions. If you can handle these, you'll have no problems with the rest of the interview."

The final step of preparation is to practice — in front of a mirror, family or friends — paying close attention to timing, inflections and tone of voice. It is also important to practice out loud. "Saying something in your mind is a lot different than actually saying it aloud," Mullinax points out.

The Interview

At this point, the physician should be ready to face the camera. His or her next important consideration is what to wear. If the interview is to be done on the job, the proper work attire should be appropriate. However, if the physician will be interviewed in the TV studio, it is best to leave the black bag and white coat behind, Mullinax says.

The key, here, is to dress conservatively. For men, this translates into dark suit, light shirt and a tie with some red in it to draw attention to the face. Women also should dress conservatively, avoiding flashy jewelry, trendy clothing or any other items that might distract the viewer, including name tags or badges.

Hairstyles, makeup and general overall appearance usually can be checked in a monitor on the set before taping or airing. And its perfectly all right Mullinax says, to pull out a comb or mirror before the show begins. Once the camera is on, the speaker should avoid fidgety movements and look at the interviewer — not the camera.

Just as important as visual appearances are vocal impressions — the tone of voice, choice of words and overall manner of presentation. "Never get mad at the interviewer," Mullinax warns, "no matter how aggravated or upset you might become. Remember, an hour after you're on the air, people aren't going to remember what you said, but how you said it. If you get aggressive or lose your cool — that's how you'll be remembered."

Next, she suggests "taking the initiative" with a technique she calls "bridging." This consists of taking a reporter's question and turning the answer into a SOCO statement that will include a message the physician would like to give. For example, a reporter's question on the role of high technology in high health care costs could be turned into a positive statement about all the benefits that have been derived from that technology.

Mullinax also suggests the use of examples and anecdotes to tell a story. "People love to hear about personal experiences," she says, "and can relate much more easily to a good example than to philosophy or statistics."

A next step is to watch for traps or tricky questions that lead the physician into making a statement — implied or otherwise — he or she does not wish to make. One example of this is the "multiple choice" question which does not include any of the right answers. For instance, the reporter might ask, "Is it the doctor or the hospital that is most responsible for rising health care costs?" A proper response would be "Rising health care costs are due to a number of factors," followed by an explanation of some of the factors that have lead to rising costs.

Physicians also should be alert for the "loaded prefaces," in which the interviewer makes a slanted statement, and then goes on to ask a question leaving the impression the statement is correct. An example: "Since misdiagnosis is a common problem in hospitals today, don't you feel DRGs will benefit patients?"

"Don't be afraid to question or disagree with the reporter's information," Mullinax says, "and never let an erronous statement stand. If you feel the interviewer has made a mistake, say so. Question his or her source of information. Set the record straight."

In turn, the interviewee also should be able to support his or her statements with factual information and — above all — must be truthful. For in spite of its brevity and seeming superficialism, TV news is one of the most effective mediums for revealing uncertainty and dishonesty, as the popular news show "60 Minutes" has so often demonstrated.

"Own up to your mistakes if you've made them," Mullinax says, "or admit there is a problem if there is one. And then go on to your bridging — and explain what positive things you're doing to correct it."

An interested public is much more likely to empathize with a physician who admits he or she is not perfect, than with one who tries to bluff his or her way through an interview, acts angered or put out, or — worst of all — is dishonest.

As many historians point out, President Nixon was chastised by the American public not so much for his mistakes, but for his unwillingness to own up to them before the camera's eye — and the public's eye. **OSMA**

Susan Porter is Assistant Editor of the **Ohio State Medical Journal.**



THE EXTRA MILE

The Pros and Cons of Marketing

By Karen S. Edwards

An issue on physician image wouldn't be complete without bringing up the subject of marketing.

After all, it is what the media training, the patient newsletters, the extra evening office hours are all about. When you strive to put your best foot forward, whether it's before your patients or the general public, you are essentially, marketing yourself — and given today's competitive climate and cooling public image — can you afford *not* to be marketing?

That was one of the questions tackled by the Ohio State Medical Association's Communications Committee recently, as it met to discuss the merits of the "Extra Mile" campaign, the marketing project launched this past spring by the Communications Department. (In order to insure that the group would speak candidly on both the "Extra Mile" and physician marketing in general, anonymity of the speaker was promised and will be preserved throughout the article.)

"As I see it," said one committee member, "the 'Extra Mile' is a consciousness-raising effort. For generations, physicians have been privileged to practice medicine without having to be concerned with the psycho-social issues which are currently involved in the patient-physician relationship. The physician used to be the only act in town. Now we're not. It has become more important than ever to make eye contact with our patients — to hold their hands and keep them informed of what is going on. If nothing else, increased competition makes us more aware of our responsibility to patients."

"Frankly, I have a philosophical problem with the OSMA helping physicians to compete effectively with

other physicians," said another member. "If the idea is to improve your practice, or to conform with the standards of a good practice, well, fine. But I can see why some physicians are against the idea."

"I don't perceive marketing as a means of taking patients away from other physicians, though," said another member. "I see it more as a matter of how a physician can keep the patients he already has. It promotes awareness — the physician begins to examine his own practice and ask himself questions — 'have I had any new patients recently?' and 'if not, why not?' He begins to think 'maybe I have a problem and don't know it'."

"At first, I thought the 'Extra Mile' and marketing in general seemed to be self-serving. Certainly some of the information contained in the kit seems obvious — but you forget how important and valuable that information is," said another.

He then dropped back to his first point.

"I think we do have to be careful, however, that we're not presented in a way that makes us appear anxious to improve our cash flow."

Another member expressed some discomfort with the idea of marketing.

"In the rush to market ourselves and our practice, I'm afraid that the discussion of quality care will be lost. I think that the role of communications today is to provide opportunities for discussion in this area."

The speaker pointed to other health care groups.

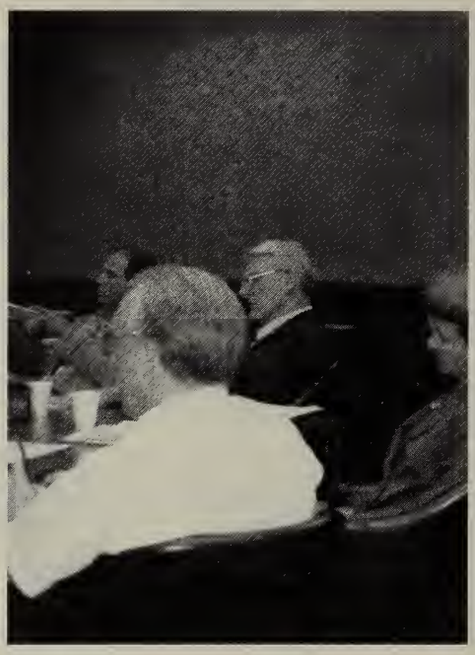
"That's what makes physicians different. We are patient advocates and we do stress quality care. We need to get the word out that physicians take their responsibility in this regard very seriously."

Another committee member agreed.

"With income comes an increased sense of responsibility. That hasn't been addressed yet, either by marketing plans or by the media. Yet, as physicians, we are concerned with the kind of care being delivered.

"I'm especially sensitive to the idea of contractual medicine, which seems as though it is more episodic than long-term care."

"Yet young people are just as happy to go to an urgent care center as they are to a family physician," said another member.



OSMA Communication Committee members.

"I don't perceive marketing as a means of taking patients away from other physicians. I see it more as a matter of how a physician can keep the patients he already has."

"Perhaps that's why family practice physicians have become so heavily involved in marketing," commented another. "The family practice group has done a very good job of introducing and encouraging marketing to their members. They have regular discussions on how to market . . ."

"But, of course, they are in the type of practice that deals more with patients," observed another. "The super specialists at the institutions do not have to market themselves. The institutions will market them.

"Actually, it is the medical student who is just beginning practice who needs the most help," he added.

Another picked up the subject.

"There is a need for marketing in medical school, but no one will do it. The medical schools won't give courses in economics or marketing."

"But the residency programs are getting more practical," said another. "And residency is really the time to teach marketing. After all, once you leave the residency program, that is when you have to market yourself."

"It's not just the residents who need training, though. Physicians as a whole, are not trained in this area. We don't know what to do. There is also the point raised earlier — that when you are talking about marketing, you are talking about more money. That's the first impression you get, and we do have to be careful that we're not being perceived as self-serving individuals. We not only need to know *how* to market — but how to market discreetly — without raising any bad public images."

The conversation then turned, briefly, to the subject of physician image.

"Studies show that while the image of the public's personal physician remains on top, the public's perception of the medical profession in general continues to decline. Why? Have we looked for an explanation, and does it make a difference? Can physician efforts at public relations really improve the image of medicine?" asked one member.

"I think the OSMA needs to continue strengthening the image of

physicians — especially as patient advocates," commented another.

Most agreed that the media is one of the best ways to get this message across.

"There is a real need in the small, rural counties to get pertinent, timely comments into the local press. We also need to let the media know that we can be counted on as a source for socioeconomic facts, as well as clinical matters."

"But that means that our members' communication skills need to be strengthened," says another. "If the media is going to use them as sources, they need to be ready to speak."

The Communications Department has attempted, over the past six years, to insure that physicians are ready to meet this obligation by providing media-training seminars, discussed elsewhere in this issue.

But what else can be done to improve the public's faltering image of the medical profession?

"I think the newspaper supplements are a good idea," remarked one, while several expressed interest in television spots.

"Other groups go on television and sell medicine to anyone who listens," they argued.

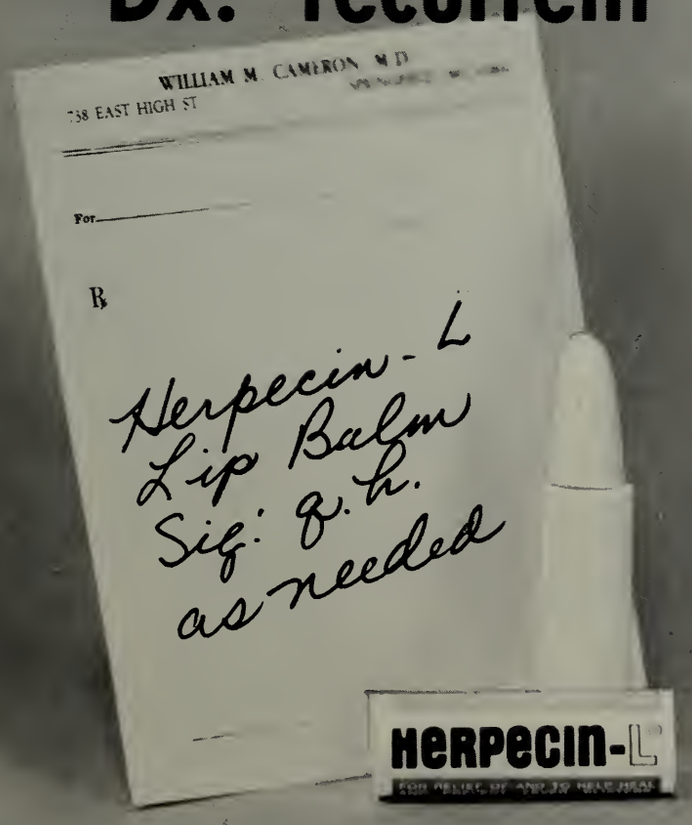
However, it was pointed out that public service announcements are expensive to produce, and since the Federal Communications Commission no longer requires television stations to devote as much air time to public service as they once did, fewer stations are using them.

"They are just not cost-effective anymore. It is probably more cost effective to teach physicians how to appear on TV . . . and it probably does more to enhance their image," said one.

That — and perhaps a good marketing program — rebutted another.

Karen S. Edwards is Executive Editor of the **Ohio State Medical Journal.**

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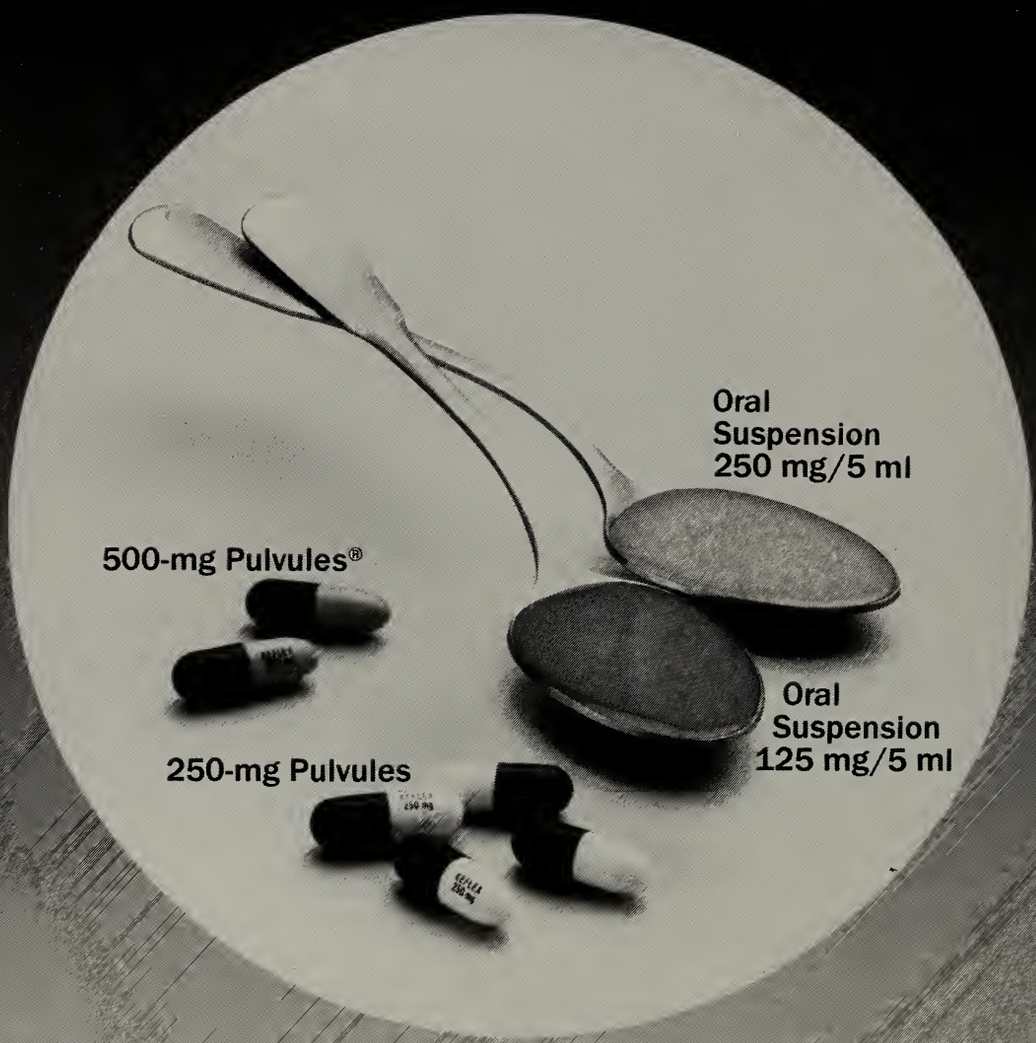
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Reconsidering Your Insurance

By Louis Saslaw

Life insurance policies may offer you a "piece of the rock," but they're not carved in it.

The flexibility of most policies allows the policyholder to stand back from time to time and review whether or not his or her objectives are being met. After all, needs and abilities may change over time, and the original reason for buying insurance in the first place may become suddenly less meaningful. Children grow up and build their own estates, for example.

If you are currently considering a review of your life insurance policy, you may wish to consider some of the other options that are available to you.

For example, you may wish to consider presenting the policy as a gift to a charitable organization, such as the Ohio Medical Education and Research Foundation (OMERF).

By giving the organization the policy and all rights to it, you would be allowed to claim an income tax deduction equal to the replacement value of the policy or its cost — whichever is lower. You would also be able to remove the policy from your estate for Federal estate tax purposes.

To illustrate the kind of savings this means, let's assume that at the age of 30 you took out a paid-up-at-65 policy, with a face value of $25,000. Assume also that you have allowed dividends to accumulate at interest. The total value of the policy, now that you've reached 65, might be as high as $49,300. Your cost (the sum of the premiums you've paid) would be around $17,500.

By giving the policy to OMERF, you would be allowed to deduct $17,500 as a charitable contribution for income tax purposes. With a current income of about $40,000 a year, this deduction could reduce your income taxes by as much as $4,804 in the year of the gift.

Another option that allows you to make a meaningful gift (while continuing to hold on to family protection) is to take out a new life insurance policy, assign it and all rights to the organization you wish to receive the gift, and claim an income tax deduction for each premium payment made. Under this plan, even if you stop paying the premiums, the organization could continue to pay the premiums on the policy itself, and eventually collect the full fact value of the policy at your death. Or, they could convert the policy into paid-up insurance, and ultimately collect a lower face value. It could even cash the policy in for its surrender value.

Individual situations differ, of course, but that's where the flexibility of life insurance becomes such an advantage — there is almost no limit to the effective ways you can use it.

Or, you could establish and assign a trust in the same manner. The fact that the property you designate will ultimately be used for charitable purposes would also enable your estate to claim a tax deduction.

Individual situations differ, of course, and the gift plans described here may not be appropriate for your particular needs and objectives. But that's where the flexibility of life insurance becomes such an advantage — there is almost no limit to the effective ways you can use it.

You could also, for example:

Name OMERF a beneficiary: OMERF could be named as either your sole beneficiary, or asked to share the proceeds with individuals or other worthwhile organizations.

Name OMERF a "contingent" beneficiary: In other words, specify that OMERF is to receive the proceeds only if the primary beneficiaries die before you do.

Remember OMERF with special policies: If you carry group term insurance provided by your employer, or flight/accident insurance, naming OMERF to receive some or all of the proceeds can be a generous gesture on your part, that could also save taxes for your loved ones.

Under all of the arrangements described above, you would retain the policy and all rights to it. You wouldn't receive any income tax deductions for the premiums you paid. But any amounts that were actually received following your death would be deductable from your estate for Federal tax purposes.

As you can see, life insurance can be an extremely versatile, low-cost source of gifts to worthy causes like OMERF.

If you would like further information on gifts of life insurance, or on other ways that you can help support the work we are doing, please contact OMERF. We'll be happy to fill you in on our plans for the future — and the part that you can play in them. **OSMA**

Louis Saslaw is Director of OMERF, and a contributing editor to the **Journal.**

New Members

BUTLER
Jay O'Flynn, Middletown
CUYAHOGA (Cleveland unless noted)
Ellen L. Abeln
Michael D. Altheimer
Philip A. Andreson
Waldo L. Avello
Anil K. Badhwar
Stephen W. Baker
Vincent James Bertim
John D. Blackman
Gary Blechman
Charles Boursier
Denis F. Branson
Billy L. Brown
Lorna P. Brown
Patrick S. Carney
Dora E. Cawley
Ying-Ming Chang, Brooklyn
Paul P. Chao, Brooklyn
Arif Z. Chaudhry
Lisa M. Cibik
Ian D. Civil
Robert S. Collins
Jose Crespin
James De La Flor
Victor E. De La Pena
Siddhartha Deb
Joseph Di Blasio
Armantina Espinosa
D. Ewing-Wilson
Rodrigo G. Garcia
Robert Edward Garrett
Harry F. Gebert
Christopher F. Gibson
Krystof Godlewski
Arthur Goldner
Lawrence P. Goldstick
Raymond G. Graber
Darryl T. Gray
Michael T. Gyves
Zamir Halpern
James L. Hauer
Juan Hernandez
Marwan A. Hilal
Thomas R. Hornick
McCallum R. Hoyt
Jo Ann Jackson
Terry S. Jackson
Michael K. Jefferson
Frederick A. Jones, Lyndhurst
Ian T. Jones
Amer M. Khiyami, Rocky River
Christopher J. Knoedler, Shaker Heights
Ajay Kumar
Robert J. La Flam
Paul A. Liefeld
Rodger D. MacArthur
James K. Massengill
Paul T. McEniery
Charlotte K. Miller
Lennart Mucke
Mahmoud Nemazee
Arnold F. Nothnagel, Lakewood
Jacob E. Nutman
Manuel Otero-Cagide
Emil Pelech
Pamela Rietschel
Kim L. Roebuck
Paul M. Ruggieri
John T. Ruth
James H. Rvoick
Richard G. Sarre
Mohamed H. Sayegh
Lori B. Schneider
Ronald M. Selby
David W. Stepnick, Euclid
Robert M. Stern
Mary L. Turkiewicz, Buffalo
Monica M. Urban
Plakkat K. Velayudhan
Jacqueline R. Walker
Neil P. Walker
Suzanne S. Wallner
Donnah W. Whitaker
Byron M. Wong
Mark A. Zoller, Willoughby
FRANKLIN (Columbus unless noted)
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John C. Bools
Nancy J. Braden
Thomas R. Brownlee
Richard E. Davis
Donald Goldberg
Sree Rama C. Gorty, Worthington
Mary L. Kiacz
Michael O'Grady
Lawrence B. Rothstein
Linda Stone, Worthington
Dale P. Svendsen
Eugene A. Woltering
LUCAS (Toledo unless noted)
Francis K. Aona, Sylvania
Peter J. Bartzen, Milwaukee
Vinod Chablani
James L. Justice
Louis J. Knoble
Kathleen A. Kruk
Michiael L. Kruk
Wendy G. Martin
Hasmukh P. Parmar
M.F. Patel
Ricardo Pena, Sylvania
Ronald D. Reynolds, Sylvania
Thomas S. Richards
David M. Rosenberg
Julio Sanguily III, Sylvania
Peter J. Vandermeer
Mark S. Worthen, Sylvania
MAHONING
(Youngstown unless noted)
Edward Cabrera
David J. Clevenson
Elton K. Gaddy
Juan Mario F. Golle, Jr.
Mary L. Groda-Lewis
Barbara M. Modic
Rashmi C. Patel
James E. Race
Jonathan E. Rubinow
Antonio P. Sison, Austintown
Gerardo H. Trillo
Wydell L. Williams, Jr.
MONTGOMERY
George Gateley Burton, Kettering
Damian M. Danopulos, Dayton
John J. Halki, Beavercreek
MUSKINGUM
Nigel F. Palmer, Zanesville
PORTAGE
Renee Caputo, Kent
SCIOTO
Norman M. Jacobs, Portsmouth
VAN WERT
Thomas Lautzenheiser, Convoy

Chelation Therapy Dangerous Procedure

One of the most dangerous medicosocial phenomena in recent years has been the appearance of "chelation clinics" for the treatment of cardiac and peripheral vascular disease, writes Alfred Soffer, MD. "Not a single reputable cardiovascular society in the world endorses chelation therapy for the treatment of atherosclerosis," he says. The procedure has been deemed of no proved benefit by virtually every medically concerned agency.

— *Archives of Internal Medicine*

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Chronic studies in rats and monkeys have shown mild renal toxicity with papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin* Tablets.
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Fluid retention and edema have been associated with *Motrin* Tablets; use with caution in patients with a history of cardiac decompensation or hypertension. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* Tablets safety in patients with chronic renal failure have not been done.
Motrin Tablets can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and on anticoagulant therapy.
Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, skin rash, weight gain, or edema.
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Incidence Greater than 1% (but less than 3%)—Probable Causal Relationship
Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).
Incidence less than 1%—Probable Causal Relationship**
Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting; anaphylaxis; bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.
Incidence less than 1%—Causal Relationship Unknown**
Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmias (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.
*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)
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Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine so alkaline diuresis may be beneficial.
Dosage and Administration: Rheumatoid arthritis and osteoarthritis. Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary.
Caution: Federal law prohibits dispensing without prescription. MED B-7-S

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Kalamazoo, Michigan 49001

J-4791 August, 1984

Obituaries

MILDRED BOWEN, MD, Cleveland; Case Western Reserve University School of Medicine, 1928; age 85; died August 21, 1984; member OSMA and AMA.

E. ADAMS DANEMAN, MD, Gambier; University of Cincinnati College of Medicine, 1947; age 59; died September 6, 1984; member OSMA.

JOSEPH G. DEEHAN, MD, Lima; Royal College of Physicians and Surgeons, Dublin, Ireland, 1957; age 56; died September 6, 1984; member OSMA and AMA.

CHARLES J. HEARN, MD, Canton; St. Louis University School of Medicine, St. Louis, Missouri, 1952; age 60; died August 26, 1984; member OSMA and AMA.

CARL F. LAUSTER, MD, Cleveland; Jefferson Medical College of Thomas Jefferson University, Philadelphia, Pennsylvania, 1928; age 83; died August 21, 1984; member OSMA and AMA.

WILLIAM MIZE, MD, North Olmsted; University of Rochester School of Medicine, Rochester, New York, 1958; age 51; died May 6, 1984; member OSMA and AMA.

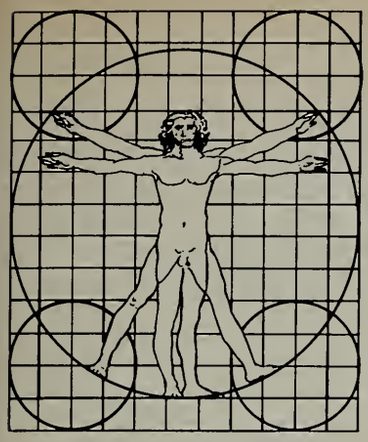
JOHN MOWRY, MD, Cleveland; St. Louis University School of Medicine, St. Louis, Missouri, 1934; age 74; died August 19, 1984; member OSMA and AMA.

BERYL M. OSER, MD, Pompano Beach, Florida; University of Virginia School of Medicine, Charlottesville, Virginia, 1950; age 62; died August 21, 1984; member OSMA and AMA.

FLORA MURPHY PEDICORD, MD, Zanesville; Ohio State University College of Medicine, 1931; age 77, died September 10, 1984; member OSMA and AMA.

ALEXANDER POLLACK, MD, Columbus; Ohio State University College of Medicine, 1939; age 68; died August 20, 1984; member OSMA and AMA.

continued on page 804



CLINICAL & SCIENTIFIC

ATTEMPTED SUICIDE IN RESPONSE TO REFUSAL OF ELECTIVE ABORTION

By Laille Gabinet, PhD

Although much has been written about the psychological sequelae of elective abortion, little is known about responses to refusal of abortion.

Passage of The Hyde Amendment has restricted availability of abortion by limiting federal reimbursement for abortions to cases in which there is a threat to the life of the mother. This ruling has had some unforeseen effects on the lives of indigent women. This paper presents three cases in which patients attempted self-abortion or suicide because they could not pay for legal termination of an unwanted pregnancy. The paper also suggests a simple set of questions for screening women for negative reactions to pregnancy.

A number of studies have been published concerning the psychological repercussions following voluntary abortions.[1,2,3,4] The state of the art has been nicely summarized in Nancy Adler's article.[5] She states that although in years gone by it was thought that the experience of having an abortion was commonly followed by serious psychiatric problems, research of the last 15 years has not supported this opinion but has shown that emotional sequelae to elective abortion constitute a minor psychiatric problem in relation to the total number of elective abortions performed.

Reports on reactions to being refused an elective abortion is much more difficult to find. The only major study of sequelae of refusal of elective abortion was published by Hook in Sweden in 1963.[6] This was an intensive follow-up study (after seven years) of 249 women whose applications for elective abortion had been refused. Of these, 86% carried the pregnancy to term, 3% miscarried and 11% procured illegal abortions. No suicides or suicide attempts occurred, although a number of the patients had made suicide threats at the time the abortion was refused.

At the time of the Hook study, legal abortion was restricted in Sweden to cases which met stringent criteria similar to those in the U.S. After abortion was legalized in the United States in 1973, there was, of course, a tremendous increase in the availability of legal abortions. Presumably, public expectations were altered by that availability. Since the Supreme Court's final ruling on the Hyde Amendment,[7] the situation has again changed, and for some people the expectation that a legal abortion will be available has resulted in disappointment.

The Hyde Amendment to the Labor-Health Education and Welfare Appropriations Bill was passed by Congress in 1976 and implemented in August of 1977, following judicial review. The amendment restricts the use of federal funds to finance abortions. Between 1977 and 1980, court actions and congressional modifications have resulted in fluctuation in the operation and provisions of the Amendment. Since the Supreme Court's final ruling in September 1980, however, federal funding has been permitted to finance abortions only to save the life of the pregnant woman.

Federal funding for medical care is used primarily to help the indigent. Although some states provide alternative financing for abortions for indigent women, Ohio is not one of them. Women who depend on federally funded health care are now finding that elective abortion is not covered. If they cannot pay for the procedure themselves, they may not be able to have it performed. This failure has led some indigent women to desperate action. Some have tried to abort themselves. Others, have attempted suicide, either in despondency or in the hope that a suicide "gesture" will qualify them for the abortion under the threat-to-life provision of the Hyde Amendment.

This paper reports three cases in which there was a direct connection between a suicide attempt and the lack of money for an abortion.*

Case 1: A 23-year-old single high school graduate. She had two living children, one of them mentally handicapped, and had had one therapeutic abortion. The patient came to the gynecology clinic when she was about six weeks pregnant, requesting an abortion. She was told to bring her money and come to the abortion clinic the next week. She failed to keep the appointment and did not reappear until three days later when she presented to the emergency room on two successive days with cramping and vaginal spotting. She was then referred to the obstetrics screening clinic where she announced that she had taken "quinine" and "Humphrey pills" (Humphrey 11: An over the counter preparation which is supposed to bring on menses. It contains cimicifuga, pulsatilla, and sepia) in an attempt to cause abortion. She indicated that she thought if she began "bleeding and bleeding" she could have an abortion without having to have any money. The obstetrician felt the patient was desperate and referred her for psychiatric evaluation.

The psychiatric interview revealed probable borderline intelligence. There were no symptoms of psychosis, but the patient appeared to be despondent. She had taken overdoses of unidentified drugs in the past following experiences of rejection by fam-

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Assistant Professor of Psychology, Department of Psychiatry, Case Western Reserve University, School of Medicine.
Submitted: February 15, 1984

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ily or boyfriend. She appeared to be ruminating about past events: parents' divorce, having been shot in the face four years earlier, and having produced a handicapped child, as well as about current hardships in caring for her two children without any help. She stated sadly that she wished she was a child again. She was afraid that she would have another handicapped infant.

The patient was judged to be at extreme risk of suicide. It was felt that she had already made an inept attempt to terminate the pregnancy and could seriously injure or kill herself accidentally or purposely if the pregnancy was not terminated. Therapeutic abortion was performed.

Case 2: A 29-year-old single woman, a high school graduate. She had had two therapeutic abortions in the past, but had successfully used contraception since that time. During the 17th week of pregnancy, she was brought to the emergency room, drowsy and with staggering gait. She said the current pregnancy was the result of a rape. She had requested termination of her current pregnancy at another hospital, but stated that she was turned away because she did not have enough money to pay for it. A week after learning she could not obtain a free therapeutic abortion, she took fifty 25 mg tablets of Imipramine. She then drank an unknown amount of whiskey. She stated she thought the overdose would kill the fetus, but that if she was not given an abortion, she would try to kill herself and the baby.

The patient was referred for psychiatric evaluation during the admission for treatment of the overdose. She exhibited no symptoms of psychosis or depression. She was known to be an alcoholic and had been considered a manipulative person who would do almost anything to attain her ends. She was consistent and firm in her statement that she had taken the overdose because she could not get a free abortion and had no money to pay for one. She stated she would make another attempt if the pregnancy was not terminated.

The patient had requested sterilization five years before. She had changed her stated reasons for the request so frequently at that time that it was felt she might regret her decision. The procedure was refused at that time and she had never repeated the request.

The patient was thought to be at risk of another serious suicide attempt. Second trimester abortion was performed, followed, at the patient's request, by tubal ligation.

Case 3: A 26-year-old divorced woman who had not completed high school. The patient had taken heroin in the past and was currently abusing unidentified street drugs. She had had one earlier pregnancy, terminated by abortion. She was first seen when she was about 10 weeks pregnant, following a suicide attempt in which she shot herself in the side. She was reluctant to communicate, but did admit that she had been depressed for the past month and had shot herself to terminate the pregnancy. She wanted very much to terminate the pregnancy, but when her boyfriend returned and promised to care for her, she changed her mind and made an appointment for a prenatal visit in four weeks. By that time the boyfriend had again left her, and she requested an abortion.

Psychiatric evaluation revealed that the patient was mildly depressed but had no symptoms of psychosis. She was considered an addictive personality, at risk of suicide if the abortion was not performed. She remained steadfast in her determination through the succeeding weeks and second trimester abortion was performed at 17 weeks.

These cases demonstrate desperate responses to the unavailability of legal abortions. In cases 1 and 2, it was established that the patients had requested abortion and had been given the impression that they could not have an abortion without money. In the third case, this information was not available. Thus, at least in cases 1 and 2, abortion refusal precipitated the self destructive behavior. Patients 1 and 3 were not able to distinguish clearly between what would abort the fetus and what would injure them.

It was not known what was actually said to any of these women about the regulations governing payment for abortions, but there is an effective communication system within the community by means of which information spreads informally. It is the author's impression that women whose medical care is supported by Medicaid have learned of the new restrictions on payments for abortion and, in instances of desperation, take extreme measures to terminate the pregnancy. More resourceful and aggressive patients often find ways of managing to get what they need from the health care system. As time goes on, more of them will learn that a suicide threat or attempt may be a sufficient "threat to the mother's life" to enable them to obtain a free abortion. For this reason, the number of incidents like those reported here may be expected to increase. Cates' article[7] estimates that 94% of low income women who wish to terminate pregnancy obtain legal abortions, despite the operation of the Hyde Amendment, through self-payment or other funds being made available. About 5% continued their unwanted pregnancies to term, and only an estimated 1% resorted to illegal abortions.

A much more pessimistic view is taken by Trussell et al,[8] who estimate that in the states they studied (Ohio and Georgia), 23% and 18%, respectively, of Medicaid-eligible women who would have obtained legal abortions before funding was restricted, failed to obtain them after the law was changed. It is the less capable patient who is unable to obtain what she needs from the system. And it is the less capable also, who are unable to think of rational alternatives to the self-destructive solutions presented in these cases.

Physicians who see patients with unwanted pregnancies can decrease the risk of suicidal behavior by inquiring into the patient's response to the news of her pregnancy. Relevant information can be elicited by several lines of questioning:

1. Inquiry about the patient's reaction to learning that she is pregnant.
2. If abortion has been requested, inquiry about her reaction to the requirements for getting it done.
3. Inquiry about what her plans are.

If the patient feels that she cannot cope with the pregnancy, wants an abortion but does not have the means, or if suicidal ideas are hinted at, the physician can help her to work toward a satisfactory solution to her problem or refer her to another staff person who can do so. This further inquiry will also help to determine whether the patient should be referred for psychiatric evaluation of mental disorder or suicide risk.

* In all the cases mentioned the information was related by the patient and could not be corroborated.

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Obituaries

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ORANGE B. POMEROY, MD, Reston, Virginia; Case Western Reserve University School of Medicine, 1923; age 88; died August 12, 1984; member OSMA and AMA.

WILLIAM L. REGAN, MD, Wilmington; University of Cincinnati College of Medicine, 1928; age 84; died September 5, 1984; member OSMA and AMA.

WOLFGANG SCHUBACH, MD, Cleveland; Medicinische Fakultat der Rheinischen Friedrich-Wilhelms-Universitat Bonn, Germany, 1949; age 64; died August 11, 1984; member OSMA.

LEON J. SHOLITON, MD, Cincinnati; Case Western Reserve University School of Medicine, 1948; age 60; died August 4, 1984.

MAURICE STILWILL, MD, Sun City, Arizona; Ohio State University College of Medicine, 1935; age 74; died September 5, 1984; member OSMA and AMA.

RUSSELL R. WAHL, MD, Toledo; Ohio State University College of Medicine, 1933; age 81; died August 20, 1984; member OSMA and AMA.

THOMAS A. WEAVER, MD, St. Petersburg, Florida; University of Rochester School of Medicine, Rochester, New York, 1938; age 71; died July 26, 1984; member OSMA and AMA.

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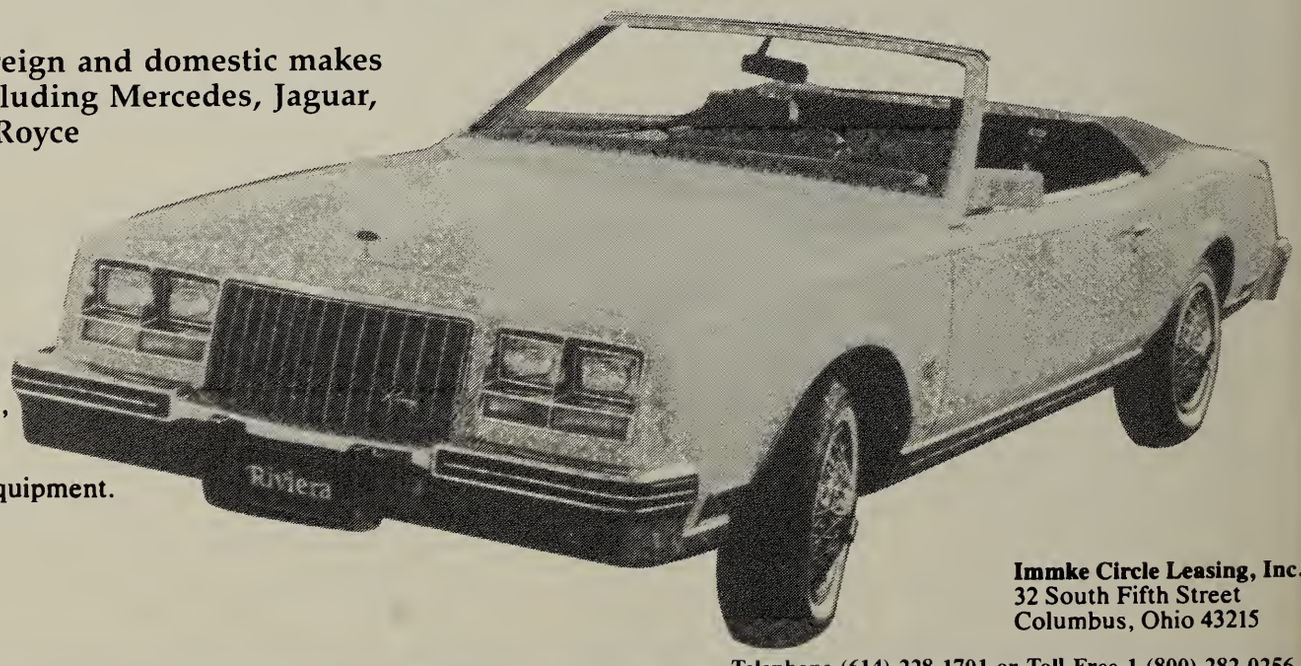
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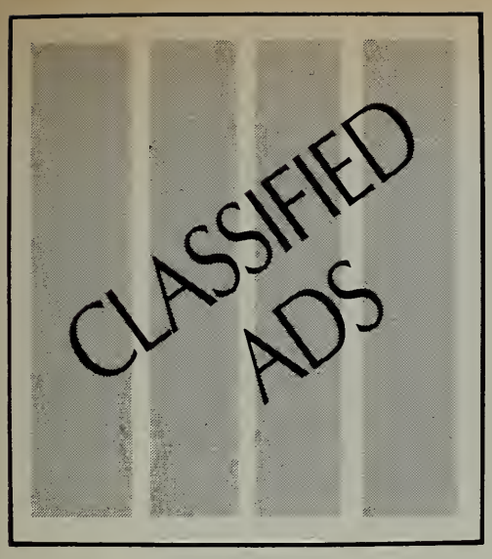
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WANTED! Top notch emergency physician to join established partnership staffing two Emergency Departments and three Urgent Care Centers in the Cleveland area. Must be residency trained, board eligible or board certified. Send CV to H. White, M.D., 1438 SOM Center Road, Cleveland, Ohio 44124.

Next month . . . place your classified ad here

Equipment

FOR SALE: due to the closing of OB-GYN practice: Midmark OB-GYN chair, model 115; Liesegang Colposcope and many more large and small items. For complete price list, write: P.O. Box 629, Mt. Vernon, Ohio 43505 or call 614/397-2859.

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Practice for Sale

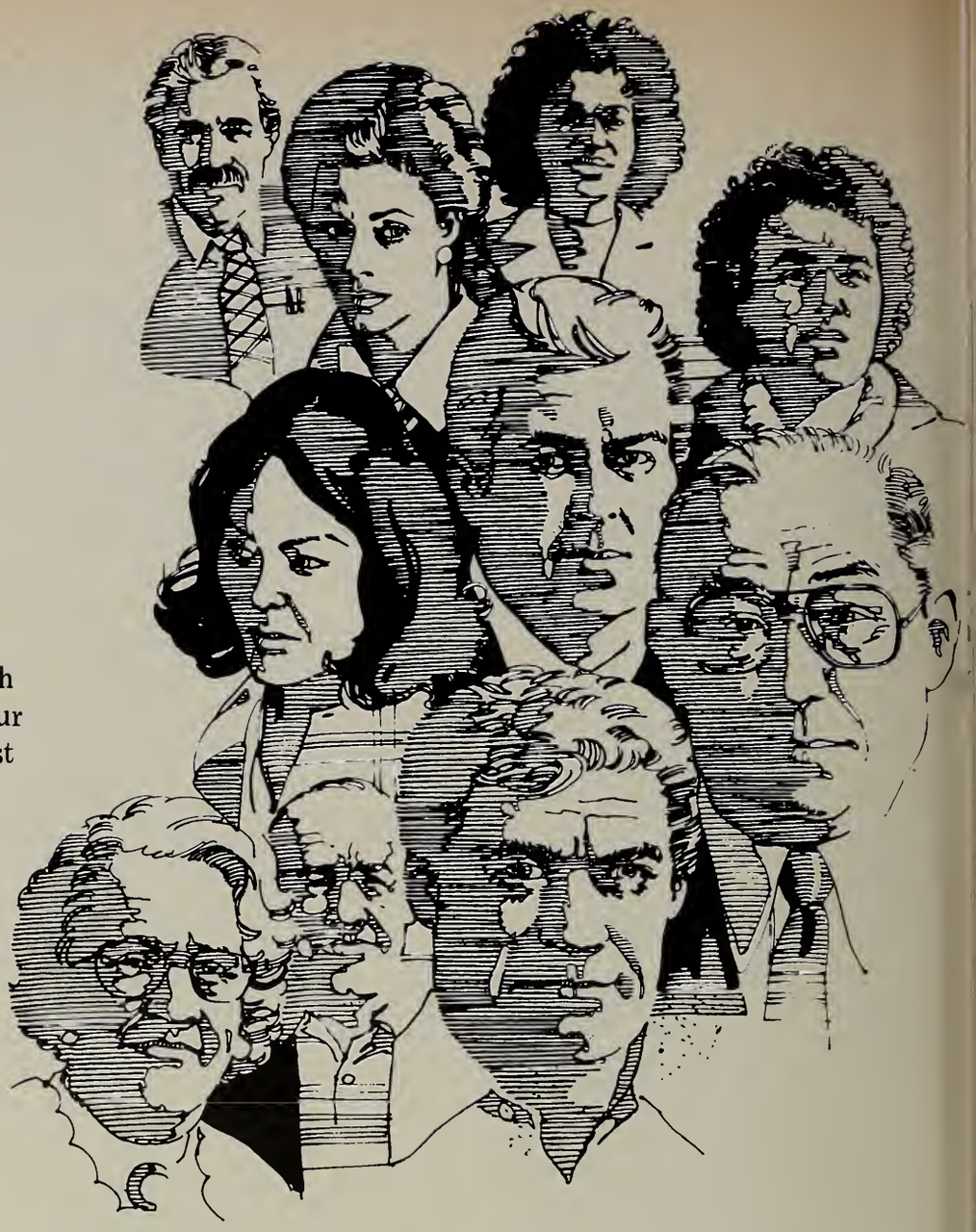
ESTABLISHED UROLOGY PRACTICE FOR SALE IN N.E. OHIO city of 20,000. Reasonably priced with seller financing available. Remodeled, well equipped office. Will introduce. Reply to M. Morgan, P.O. Box 391147, Solon, Ohio 44139.

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FOR SALE: Family practice in North Columbus. Enough office space and equipment for two doctors. Reply to Box No. 14721, Columbus, Ohio 43214.

Giving:

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The Ohio Medical Education and Research Foundation can suggest ways to make your charitable contributions work to your best advantage. Below are ten ways of giving which may meet your charitable goals.

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- Real Estate
- Life Insurance
- Through your corporation
- Memorials
- Livestock
- Intangibles
- Income producing gifts

Let OMERF help you make the right decision.

Please send me more information on ways to make a contribution.

Name_____

Address_____

City/State/Zip_____

Telephone_____

Mail to: OMERF, The Ohio State Medical Association, 600 S. High St., Columbus, Ohio 43215

Practice Wanted

BOARD CERTIFIED PEDIATRICIAN would like to buy or join either a pediatric or family practice in Dayton or Cleveland area. Reply to Box No. 36, c/o Ohio State Medical Journal, 600 S. High St., Columbus, OH 43215.

Real Estate

FOR SALE: Northwest Michigan Condominiums, in Frankfort, "THE BLUFFS." Panoramic view of Lake Michigan, gorgeous sunsets, situated in a quiet grove of stately hardwoods, all within city limits. Great fishing and skiing, excellent golf and swimming nearby. 3 BR, 2 bath, fireplace, private outdoor deck, over 1600 sq. ft. *plus* large storage room, laundry room and drive under garage. Approximately $102,000. Call Vaughan Realty in Frankfort, 616-352-4771.

FOR SALE: 2 bedroom water front house in Palmcoast, Florida. Good price. Call (419) 325-2169.

FOR RENT: Florida, Sanibel Island Pointe Santo, 2 BR, 2 BA, Penthouse A.C., Beach, Pool, Jacuzzi, Tennis, Porch, Sun Deck. Phone: Roger H. Princell, MD. (513) 523-5375.

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Intensive 4 week program beginning June 10-21, 1985 and continuing October 21-25, 1985 and March 17-21, 1986. The one-week continuation portions may be taken in successive years. Clinical and Administrative Occupational Medicine, Epidemiology and Biostatistics, Industrial Hygiene, Toxicology, Regulations, etc. 111 Cat I and Prescribed AAFP credits. 9th year. References from past participants provided. $600 per week. Sidney Lerner, M.D., College of Medicine, Mail Location 182, Cincinnati, Ohio 45267-0182, 513-872-4043.

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Colleagues In The News

Edited by Doug Evans

THEODORE J. CASTELE, MD, Cleveland, has received the distinguished service award from the Academy of Medicine in Cleveland. The award recognizes Dr. Castele's commitment to the community, medical profession and peers.

C. DOUGLASS FORD, MD, Toledo, was recently presented a distinguished citizen's award by the Medical College of Ohio. Dr. Ford is an associate clinical professor at the school and a past president of the OSMA.

C.W. HOLCOMB, MD, Richwood, has been elected president of the medical staff at the Charles B. Mills Center in Marysville. **DONGMIN KIM, MD,** Columbus, was elected vice-chairman of the facility's medical staff.

DANIEL KRAMER, MD, Cleveland, has been appointed chairman of the Cleveland Hearing and Speech Center and will serve as a member of the CHSC board of trustees.

RAYMOND S. LUPSE, MD, Youngstown, has been elected to the board of trustees of the American Cancer Society, Ohio Division, Inc. He will serve a two-year term on the state board of trustees as a volunteer representative of Stark, Mahoning and Columbiana counties.

STANLEY R. MOHLER, MD, Dayton, has been awarded the 1984 Laurence P. Shaples Award from the Aircraft Owners and Pilots Association. Dr. Mohler, currently a professor and vice chairman of the Department of Community Medicine at Wright State University, accepted the award which recognizes contributions to the field of general aviation.

IRWIN B. MOORE, MD, Cleveland, has been awarded membership in the American College of Physician Executives after having attained the highest level of achievement in both the practice of medicine and the management of health care organizations. Dr. Moore is president and chairman of the board of directors of Mednet in Cleveland.

PETER NIMS, MD, Troy, has been elected president of the Miami County Medical Society. Other officers are **DEAN LANDES, MD,** Troy, president-elect; **DONALD LUNA, MD,** Piqua, secretary; and **MARK PETERS, MD,** Tipp City, treasurer.

LUCY OXLEY, MD, Cincinnati, has been named Family Physician of the Year by the Ohio Academy of Family Physicians. Dr. Oxley is the first women to receive the award which honors her outstanding service to humanity through family practice.

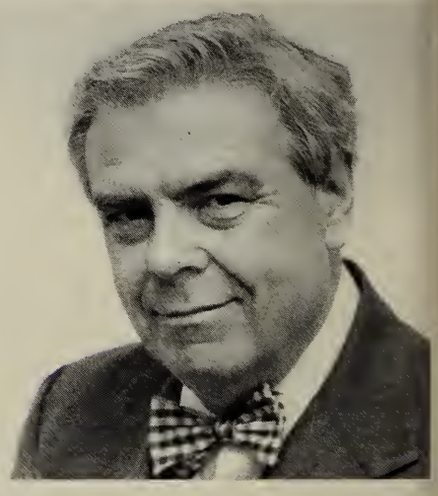
BRUCE ROTHMAN, MD, Akron, is the recipient of the first Doug Dieken Award for Courage. The award was created by the Fall's General Hospital Psychiatry Department in the name of the Cleveland Brown's team captain to recognize a physician for his courage, community commitments and contributions.

TIMOTHY L. STEPHENS, MD, Cleveland, has been appointed to the Ohio State Medical Board by Governor Richard Celeste. Dr. Stephens will serve on the board until March, 1989.

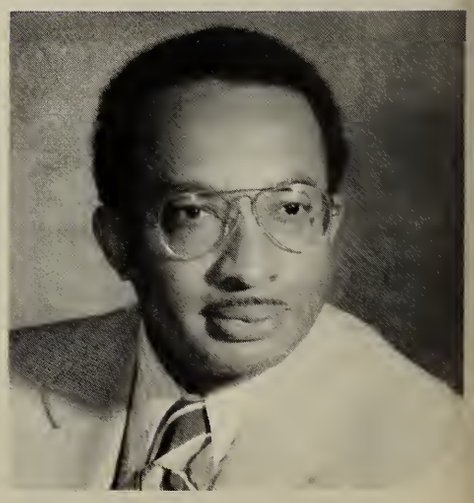
GENE WRIGHT, MD, Lima, was recently honored by the Medical College of Ohio at a Lima Rotary Club meeting for his role in establishing and developing the Area Health Education Center Program in northwest Ohio.



Theodore J. Castele, MD



C. Douglass Ford, MD



Timothy L. Stephens, MD

Simple to take.

In acute exacerbations of chronic bronchitis

- Clears susceptible pathogens from sputum[1-4]
- Reduces cough and sputum volume[1-4]
- Reduces evidence of inflammation[1]

Bactericidal *in vitro* against *H. influenzae* (nontypable strains)

Bactrim shows high activity *in vitro* against most strains of *H. influenzae*—even ampicillin-resistant strains. However, *in vitro* data do not necessarily correlate with clinical results.

In morphologic studies,[5] cultures of *H. influenzae* were exposed to Bactrim at 5 × MIC. After just four hours, bacteria began to form filaments, indicating an alteration in the normal pattern of cell division. After 12 hours, virtually all bacteria had formed filaments. When these bacteria were removed and recultured in drug-free nutrient medium, almost all were unable to divide and form colonies—a result interpreted as demonstrating that, at the above concentration, the effect of Bactrim on the *H. influenzae* was bactericidal.

Also effective against susceptible strains of *S. pneumoniae in vitro*

In sputum cultures of *S. pneumoniae*, 91% of strains were susceptible to Bactrim.[6]

In acute exacerbations of chronic bronchitis involving *S. pneumoniae* or *H. influenzae*, sputum cultures taken seven days after a two-week course of therapy showed that Bactrim eradicated these bacteria in 91% (50 of 55) of the patients treated.[5]

Effective–and economical–antimicrobial therapy

In three double-blind studies, Bactrim DS *b.i.d.* was unsurpassed by ampicillin *q.i.d.*[1-3]

And in ten clinical comparisons with tetracycline involving nearly 700 patients, Bactrim proved comparable on major clinical parameters: change in sputum purulence, reduction in sputum volume and microbiological clearance of pathogens.[4]

And equally important: the convenient and economical *b.i.d.* dosage of Bactrim DS is designed to encourage patient compliance.

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(trimethoprim and sulfamethoxazole/Roche)

Consistent success on a *b.i.d.* schedule

Please see references and summary of product information on following page.

References: 1. Chodosh S: Treatment of acute exacerbations of chronic bronchitis: results of a double-blind crossover clinical trial, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts*. Princeton Junction, NJ, Communications Media for Education Inc., 1980, pp. 15-16. 2. Chervinsky P: Double-blind clinical comparisons between trimethoprim-sulfamethoxazole (Bactrim™) and ampicillin in the treatment of bronchitis exacerbations, *Ibid.*, pp. 17-18. 3. Dulfano MJ: Trimethoprim-sulfamethoxazole vs. ampicillin in the treatment of exacerbations of chronic bronchitis, *Ibid.*, pp. 19-20. 4. Medici TC: Trimethoprim-sulfamethoxazole (Bactrim™) in treating acute exacerbations of chronic bronchitis: summary of European clinical experience, *Ibid.*, pp. 13-14. 5. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 6. The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter 1983.

BACTRIM™ (trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100, 250 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted): Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215. Phone: 614/228-6971.

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1984 Subscription: $15 per year, single copy $2 outside U.S. $20 and $3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Second Class Postage paid at Columbus, Ohio and at additional mailing offices.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.



Getting a Handle on Your Practice

Just keeping up with your patient load seems to be enough to handle, but, as a physician, you have other things to worry about as well. After all, there is continuing medical education, hospital committee work, the latest government regulations to study, and now you're supposed to make decisions on the best way to market yourself in an increasingly competitive environment. So, how can you be expected to know how the business side of your practice is running? Isn't that what office staff and office managers are for?

Certainly the personnel in your office will facilitate the day-to-day business your practice generates, but the bottom line is *you* are the decision maker; *you* are responsible for establishing office policy, determining the type of practice you want, selecting a computer (if you decide your practice needs a computer) — even hiring those people who you hope will keep your office running smoothly.

Unless you are working on a contractual basis, you *do* need to concern yourself with the business side of medicine, for your practice, to a large extent, depends on the way you conduct business.

To help you get a better handle on your practice, we decided to take a look at some of the decision-making that is going on in doctors' offices today, and provide you with a glimpse of how some of these decisions are being arrived at — by your colleagues, and by experts in their fields.

Did you ever wonder, for example, whether you should remain a solo practitioner, or perhaps take in a partner? Maybe you've even thought about incorporating . . . A Columbus attorney gives you the pros and cons of each form of practice — solo, partnerships and corporations, as well as some advice on how to select the type of practice that is right for you.

Unless you are working on a contractual basis, you do need to concern yourself with the business side of medicine, for your practice, to a large extent, depends on the way you conduct business.

If unpaid accounts are proving to be your practice's nemesis, you'll want to read how one Cincinnati physician handles the problem — and don't miss the article which surveys the computer field and lets you know just what is available to you in terms of computer software and hardware for your office.

Choosing your advisors can be tricky — but few practitioners can be without an accountant, attorney and office manager, so we've included an article which provides tips on how to select the best — as well as an article that tells you how to recruit, manage and evaluate an office staff.

Finally, we take a look at the Physicians Administrative Corporation of Ohio (PACO), the practice management arm of the Ohio State Medical Association. The company is three years old now, and we discuss with PACO President David Pennington the company's growth over the past three years — as well as its plans for the future.

So, take a look through our special Practice Management issue. Maybe it will help you get a handle on *your* practice. — *Karen S. Edwards*

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THE Ohio STATE Medical Journal



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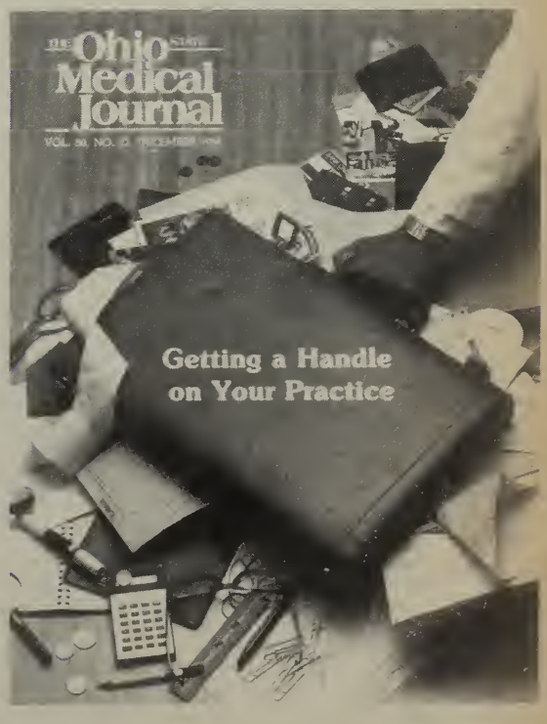
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OMERF ... Its success means our success

By A. Burton Payne, MD

It is this time of year that seems to bring out the best in people . . . remembering the good deeds of friends, lending support to those in need and above all, reflecting on the true spirit and intent of this holiday season. It is in this spirit that I write to you about our newest child, OMERF, and what your support will mean to the future of our profession.

The Ohio Medical Education and Research Foundation (OMERF) was reactivated in July, 1983. The impetus for its reactivation came from two sources: the medical student members in Ohio and the Committee on Impaired Physicians.

From information gathered from the Association of American Medical Colleges and from an in-house survey, the OSMA learned that the cost of medical education in Ohio has increased, on the average, more than 20% per year for the past three years. A medical student at Case Western University has seen his/her tuition alone increase from $7,000 to $11,200 in the past two years. Similarly, a single medical student at the University of Cincinnati can anticipate total expenses exceeding $18,000 per year.

While these increases have taken place, the Federal Government has reduced the amount of federal assistance available for graduate and professional students. An alternative program, the Health Education Assistance Loan (HEAL), was instituted but charges the borrowing student interest at extremely high rates. What is worse, interest payments begin three months after the student graduates. The implications of the HEAL program are staggering. If, for example, a student were to borrow $80,000 over the course of four years, the graduating student would be faced with a payback of more than $700,000 over a 20 year period.

OMERF wants to be able to provide low interest *loans* to needy students. We simply want them to have a debt level that they can manage instead of a debt that will manage them.

OMERF wants to be able to provide low interest loans to needy students.

OMERF's next area of interest is the impaired physician. The Impaired Physicians Committee of the OSMA identified numerous cases of practicing physicians who had become impaired and successfully completed rehabilitation. These physicians, however, lack the resources necessary to return to practice. OMERF wants to help these recovered physicians with low interest loans. All requests for funds would be reviewed by the OMERF Board of Trustees on an individual basis. It is anticipated that requests for these funds would be limited.

The last major area of interest for OMERF is consumer health education. In this regard, OMERF would like to support special projects of research and education. Many projects have been developed by community agencies, yet they lack the resources to proceed with their new ideas. With OMERF properly funded, an agency could apply for an OMERF grant. Examples of such programs might include support for an additional research fellow at a university, support for a "stop smoking" day, a county-wide diabetes screening program, etc. Obviously, any program seeking support would be reviewed by the OMERF Board of Trustees.

In summary, OMERF is dedicated to preserving excellence in medicine. It wishes to provide any future physician, regardless of his or her socioeconomic background, the opportunity to study medicine if he/she so chooses.

OMERF is similarly committed to its practicing physicians, who for whatever reason, have lost their ability to practice but have recovered from their impairment.

Finally, OMERF belongs to the consumer. It wants to be available to educate the patients on *wellness*.

Please take a minute and donate to OMERF the cost of an office visit. Your collective support will ensure both quality and equality in the practice of medicine. **OSMA**

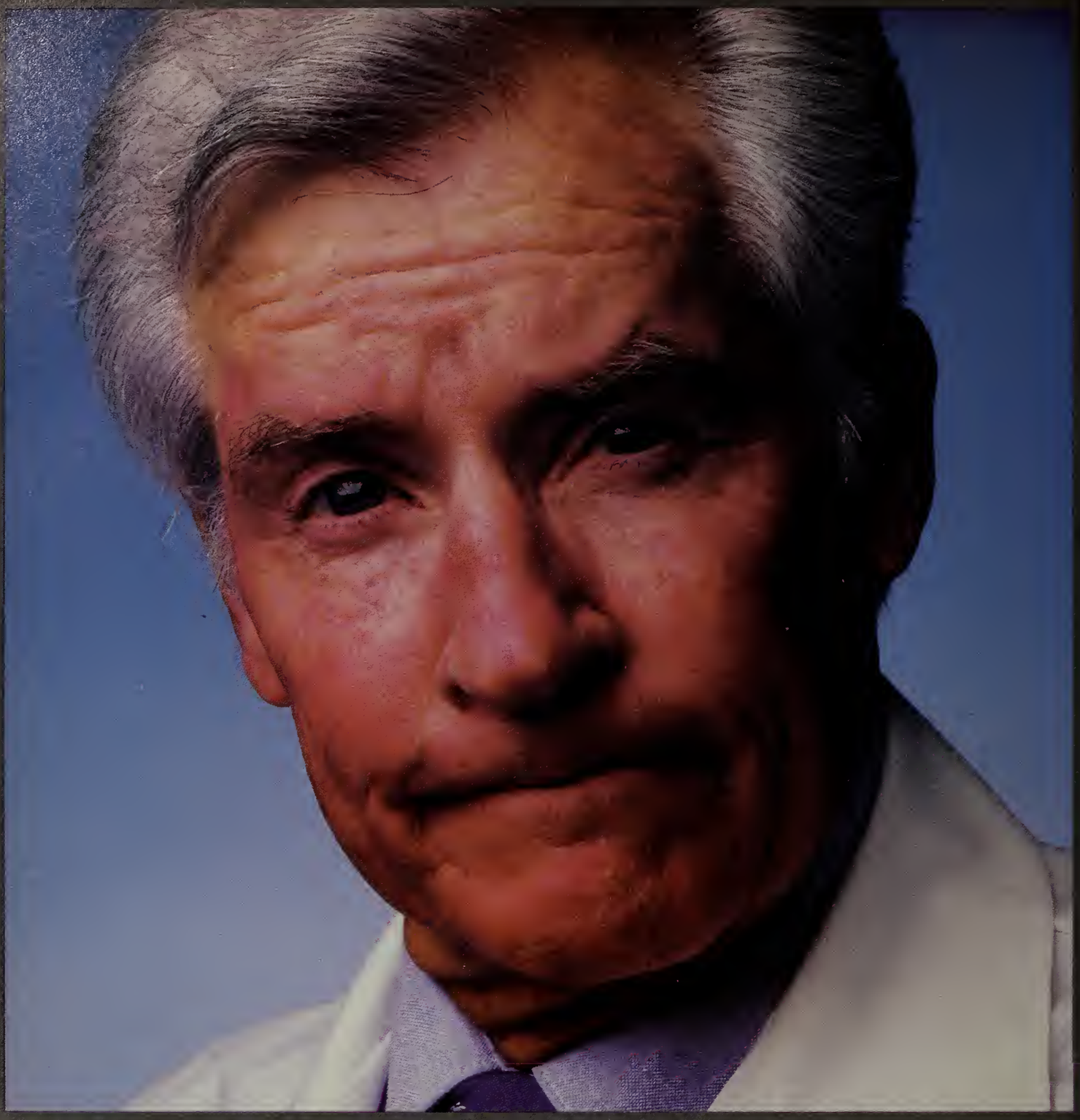
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Give Them a Dose of Their Own Medicine

By James David Brodell, MD

I am not sure how many years ago it was. I may only have been in junior high school here in Warren, but I remember the sadness which came over me when I heard that one of the young Kennedys had been afflicted with bone cancer. I was an ardent Kennedy supporter because I thought the concept of National Health Insurance was important. I believed all people in this country should have equal access to health care and that one doctor was just as good as another. It was not long thereafter I heard the young man had been taken to one of the most famous hospitals in this country and he had the best doctors available. Because of this, at the time, the prognosis was said to be favorable. I sincerely hope he is continuing to do well. May he always be able to reap the benefits of this country's finest medical care.

One thing bothered me back then. I thought, for the first time, about what it would be like if there was a National Health Insurance System and if we could not choose the doctor we wanted. I wondered what the Kennedys would have done since Senator Edward Kennedy authored and sponsored the concept. Would they have gone to the local orthopaedic surgeon down the street and taken their chances? The answer was "NO" then and it is "NO" now! The Kennedys took their son to the best doctor they could find and I would assume they took the position that money was no object. They would do the same thing today if another member of their family became ill. We all want the best for our family and friends. This, then, is the enigma and tragedy of the lawmakers in this country. They make laws for all of us except themselves.

It is intriguing to ask: Exactly how many politicians and their families will join HMOs over the next 10 years and how many of them will allow DRGs and other government controls to affect the health of themselves and their families? Probably, not many!

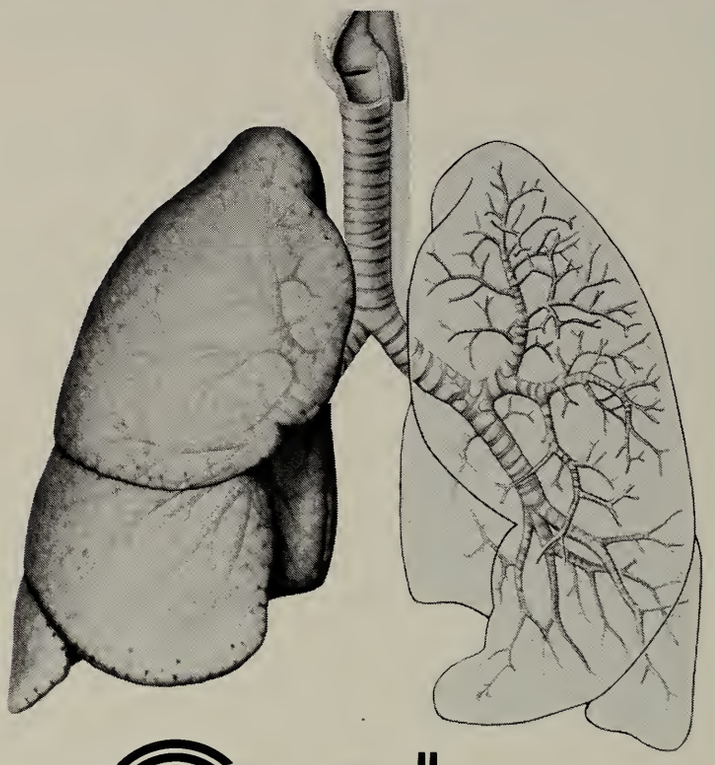
Those people who promote laws and guidelines which hinder the free practice of medicine in this country should be required to actively participate as patients in the socialized system.

My biggest fear is that after the government socializes and thus ruins the free health system, the frequently wealthy politicians will still have access to good quality private care. This ultimate in hypocrisy and double standard says, "What is good for the country isn't good for me," and "Everybody stay on ship here where it is safe, I'm just taking this lifeboat for a short cruise."

I would propose the quickest way to remove government controls from the health care industry would be to legally mandate that those members of the legislative, executive and judicial branches of government who propose, pass, interpret and enforce those controls be required to actively participate in the socialized system. For example, if a senator proposes or votes for legislation giving favorable status and advantage to HMOs, then he and his family should be required to be a member of an HMO. If a representative passes a law restraining or prohibiting the development and implementation of new technology, then he should be required to be diagnosed and treated by the old technology. If a congressman promotes the usage of generic drugs regardless of therapeutive efficacy, then make it illegal for him to get quality brand name drugs. If a member of the executive branch promotes laws placing DRGs into hospitals, then make him leave his hospital bed when his time is up regardless of his condition. If a lawyer argues and/or judge rules it is illegal to remove life support systems in a hopeless case, then treat them the same when they are terminally ill and subject them to the inhumane torture they have reaped upon others. I could

continued on page 823

Consider the causative organisms...



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H. influenzae, H. influenzae, S. pyogenes
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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile.* Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor* (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbiliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Letters to the Editor

TO THE EDITOR:

I wish to disclaim credit for the article, "Investing in Gold Loses its Sparkle," that appeared under my by-line in the October issue of *The Ohio State Medical Journal.*

The title, format and style are not mine. Other alterations are grossly inaccurate and must not be attributed to Mr. Cullman or me. The published article is not one on which I would have allowed my by-line if I had been consulted.

Signed,
Joan S. Fulton
(Mrs. Richard L. Fulton)

Editor's Note: Established *OSMA Journal* guidelines were followed in the editing of this article. We regret the author's dissatisfaction.

WANT TO EXPRESS AN OPINION?

The OSMA Journal *welcomes letters from its readers. Please address all letters to: Executive Editor, 600 S. High St., Columbus, Ohio 43215. Letters may be edited to meet space requirements*

Second Opinion

continued

go on, but the point has been made.

Those people who promote laws and guidelines which hinder the free practice of medicine in this country should be required to actively participate as patients in the socialized system. They should not be allowed to buy their way into the private, free sector while legislating restrictive care for the rest of the population. This is the only way I know to educate these people about the damaging effects of their health care meddling.

Either we all sail free or we all go down together. This is the American way. The system they create is the system they must use. Unfortunately, it may take quite a few sick politicians before the overall health of our system starts to improve. So first, we must insist they get a generous dose of their own medicine! **OSMA**

Dr. Brodell practices orthopaedic medicine and surgery in Warren, Ohio.

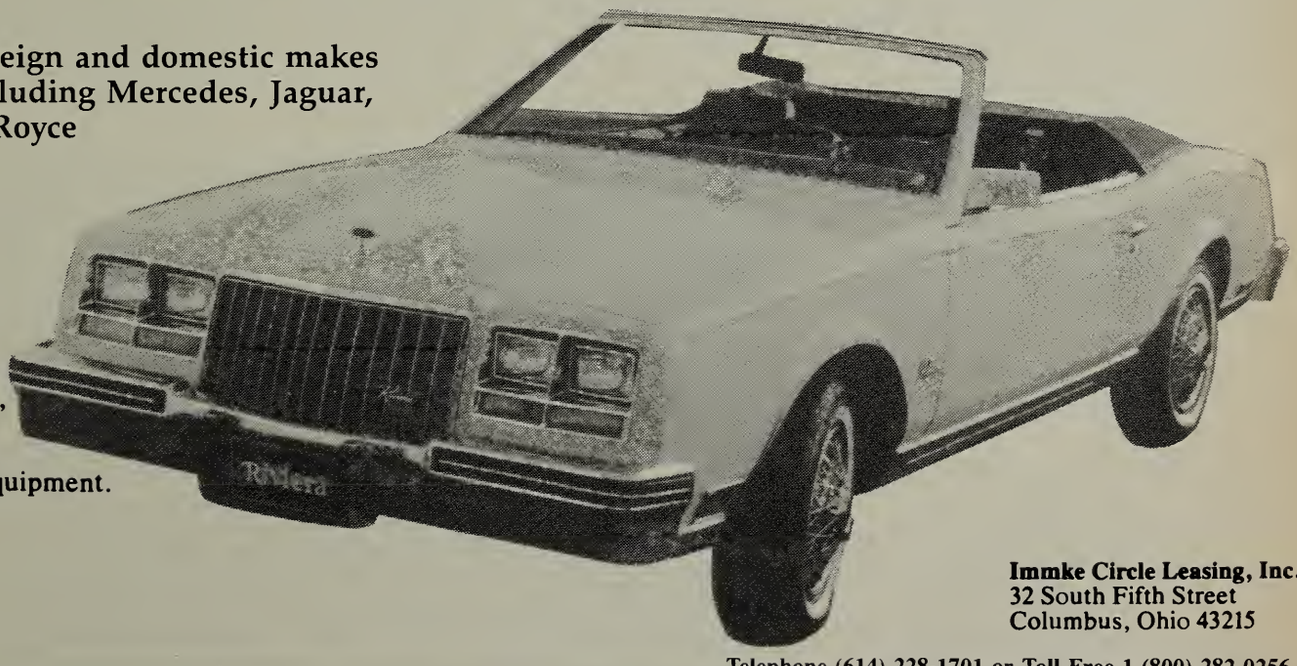
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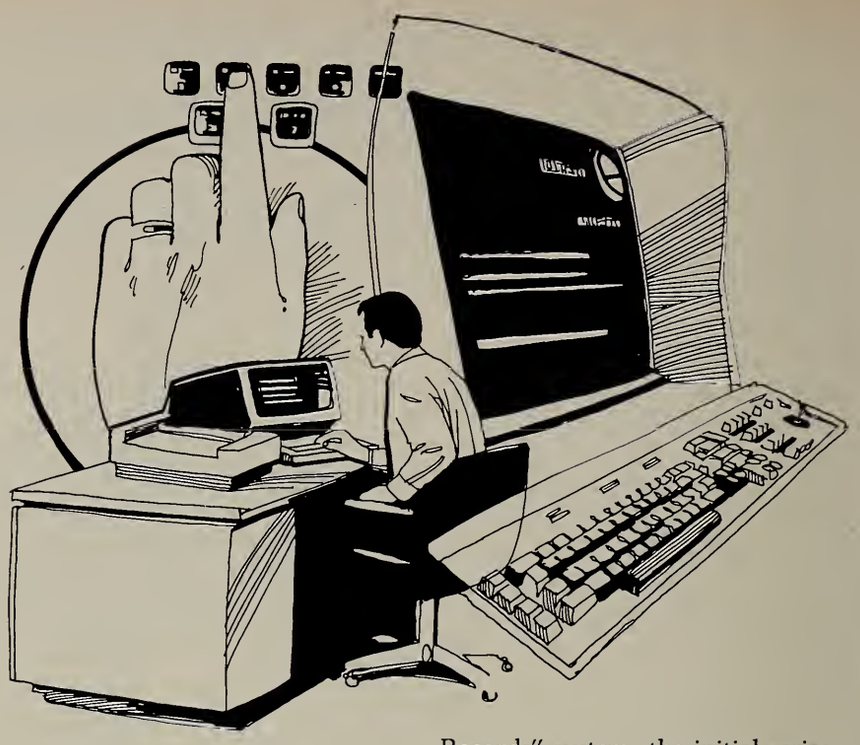
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NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by Susan Porter

Home computers keep medical records



Home computer owners can now keep a complete set of family medical records at their fingertips, thanks to a new software series called "To Your Health," released by publishing corporation Avant-Garde.

"Medical Records," the first of the series, organizes all of the family's health information — including physicians visits, x-rays, lab tests, immunizations, school requirements, and other vital facts — and keeps it ready to print out individually, as needed.

In addition to the "Medical Records" system, the initial series, titled "An Apple A Day . . ." also includes:

- "Emergency Health Telephone Directory," which keeps on file important names, addresses, telephone numbers; lists directions to the nearest emergency room; and files special "hot line" numbers separately for easy retrieval, and
- "Health Advice," which helps a family treat and prevent common medical problems at home.

The series is available to owners of the Commodore 64, Apple II, IBM PC and IBM PCjr.

Government, drug industry to tackle health care frauds

The federal government and the drug industry are joining forces to launch a massive campaign to combat medical frauds which bilk consumers of about $10 billion every year, says the commissioner of the Food and Drug Administration in a recent UPI report.

The first phase of the drive is a public service ad campaign. About 4,500 advertising agencies and 1,000 health care companies have been invited to enter ads to alert the public about dangers of health fraud.

The FDA has set up nine categories of health fraud: figure enhancers, arthritis and pain, sleep aids, hair and scalp devices, youth prolongers, sex aids, disease diagnosers, cure-alls, and respiratory, pure air and water devices.

The campaign is supported by the Council of Better Business Bureaus, the American Medical Association and the American Pharmaceutical Association.

BRIEF NOTES . . .

•In the marketplace — you're not alone

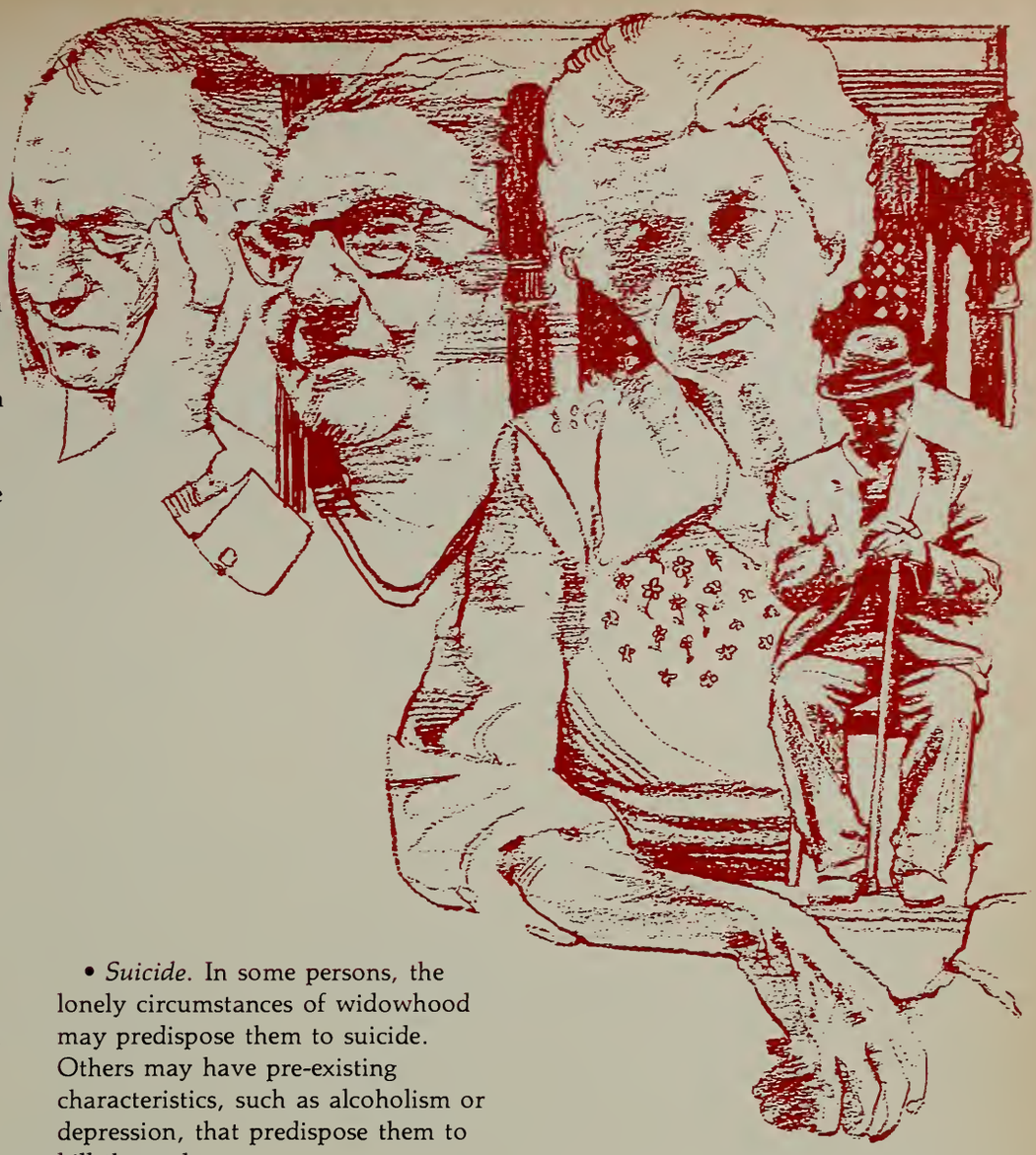
Close on the heels of last month's news item which stated that enrollment at medical schools continues to follow a three-year pattern of decline comes this report from the Law School Admission Council: "After 20 years of steadily rising law school enrollments, the number of law school applicants has declined by 11.4%."

An editorial which appeared recently in the *Columbus Citizen-Journal* chose to sum up the subject in this way: "While prestigious law schools still have more applicants than they can accept, competition in the marketplace has made lawyering no longer the golden career it once seemed to be."

•Business and health care — involvement increases

Medical society involvement in health care coalitions increased this year compared with last year and the year before. A survey conducted by the AMA Department of Health Care Coalitions found that more than half (31 out of 54) of the responding state medical societies said that they were involved. The total number reporting involvement in 1984 (164) is a 45% increase over 1983 (113) and a 169% increase over 1982.

Survivors prone to premature deaths



Epidemiological studies now confirm what has long been suspected: the death of a spouse or close family member may result in premature death for survivors, according to a National Academy of Sciences report.

A number of studies reviewed in the report suggest that bereavement may enhance vulnerability to:

• *Cardiac arrest.* Sudden cardiac death, cardiac arrhythmias, myocardial infarction, and congestive heart failure are the most frequently mentioned conditions following the death of a close family member.

• *Infectious disease.* Grief — like stress, depression and panic disorder — may influence the body's hormonal milieu and cell-mediated immune mechanisms. Thus, by compromising the immune system, grief may alter the body's resistance to infectious agents.

• *Neoplastic disease.* Alternations in hormonal milieu following bereavement may have clinical importance to hormone-sensitive cancers such as estrogen-dependent breast cancer and testosterone-dependent prostatic cancers. Further studies are needed of ovarian, testicular and adrenal hormone regulation in bereavement and of the hypothalamic-pituitary stimulating hormones that control these target glands, the report states.

• *Suicide.* In some persons, the lonely circumstances of widowhood may predispose them to suicide. Others may have pre-existing characteristics, such as alcoholism or depression, that predispose them to kill themselves.

Some individuals are at greater risk than others following the death of a loved one, the report notes. Young and middle-aged widowers are most vulnerable to disease during the first year after death of a spouse and continue to be vulnerable for as long as six years if they do not remarry.

In general, bereavement reactions are more intense and have more enduring consequences for young people, particularly chidren in their early teens. Girls under 11 years who lose their mothers and adolescent boys who lose their fathers are at particular risk.

State launches study of psychiatric patients

The state has recently launched a $180,000 study to determine how many of the 4,100 persons in the state's 17 psychiatric hospitals may be there primarily because they are drug addicts or alcoholics.

The purpose of the study, says Paul Coleman, consultant on recovery services to Governor Richard Celeste, in a recent *Columbus Dispatch* article on the subject, is to determine the primary cause of the symptoms psychiatric patients are exhibiting.

"Misdiagnosing victims of chemical dependency is a disservice to the persons involved and to taxpayers in general," he was quoted as saying. Coleman pointed out that addiction-recovery services usually can be provided more cheaply than psychiatric care.

Those involved in the project hope that, with proper diagnosis and subsequent detoxification for those who are found to be substance abusers, many patients can be released from the state's hospitals to cheaper, community-based alcohol and drug recovery programs.

The initial study will be at Rollman Psychiatric Institute in Cincinnati, and, if results prove beneficial, will be expanded to other institutions.

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Ohio's Health Care:

The State's Strategic Plan

By Karen S. Edwards

Since early this year, the State of Ohio has been working on ways to meet the most critical needs of its citizens — without spending excessive funds to meet those needs.

In order to accomplish this, strategic planning sessions have been organized around four major issues: jobs and Ohio's economy; social issues; the environment; and state government — with reports listing goals, and initiatives to meet those goals following each session.

The most recent report, entitled "Toward a Working Ohio," and subtitled "A Strategic Plan for the Eighties and Beyond," explores the social issues and attempts to "synthesize" a concern for people with a growing concern for spending money wisely.

"These are tough times," writes Governor Richard Celeste in the report's forward. "This plan reflects our commitment to target our limited resources at those objectives that will make the biggest difference to the lives of Ohio's citizens."

Many of the issues which this particular report addresses involve health care — and it specifically points to environmental health, health care costs, alcoholism and drug abuse, and mental disabilities as areas that will need the state's attention in the future.

In an attempt to meet these recognized health care problems, the state planning group has set forth the following goals.

GOAL: To create opportunities for all Ohioans to achieve the highest possible quality of life . . . by:

Initiatives: 1.) *Investing in prevention and early intervention programs.*

The state hopes that by strengthening and creating preventive and early intervention programs in health and other social service agencies, serious health problems can be caught before they're too costly — or too late. Examples which the report

Many of the issues which this particular report addresses involve health care — and it specifically points to environmental health, health care costs, alcoholism and drug abuse, and mental disabilities as areas that will need the state's attention in the future.

The state believes that prepaid health care systems emphasize prevention of health problems and thus give health care professionals incentives to offer services in a cost effective way.



offers are: creation of maternal, prenatal and child health care clinics; expansion of programs in schools for child abuse, health care, drug and alcohol abuse and teenage pregnancies; development of general health promotion and health education programs in the schools and the promotion of health education and preventive health programs for older Ohioans.

The state will also help establish a network of local alcohol and other drug abuse programs in areas where none currently exist, and it will work with business, labor and local service agencies to encourage a greater emphasis on prevention and treatment in this area.

2.) *Improving the ability of individuals and families to meet their basic needs.*

The state will assist communities in establishing and expanding community-based services for older Ohioans and for people who are physically, mentally and developmentally disabled.

GOAL: To contain the growth of expenditures while enhancing the quality of service . . . by:

Initiatives: 1). *Establishing new standards for capital investments and health care reimbursements.*

The state will take a three-pronged approach in achieving this initiative. First, it will attempt to control the supply of hospital facilities and services through an upgrading of Ohio's Certificate of Need program. Second, it will encourage hospital efficiency and slow the rate of growth of hospital costs through designing and implementing a prospective reimbursement system (DRGs), for Medicaid admissions to hospitals in much the same way as the DRG system was implemented for Medicare patients two years ago. Finally, it will require pre-admission approval for non-emergency admissions to hospitals.

2.) *Developing mechanisms for reducing the public costs of human service programs.*

The state is committed to increasing the use of primary care systems, including health maintenance organizations, by Medicaid recipients. The state believes that prepaid health care systems emphasize prevention of health problems, and thus give health care professionals incentives to offer services in a cost-effective way. Therefore, the state's Department of Human Services will seek to increase enrollment of Medicaid recipients in additional HMOs, and will explore the feasibility of using primary care systems for the delivery of health services to state employees.

In another attempt to reduce public costs, the state hopes to expand opportunities for home and community-based services for persons who would otherwise require institutionalization or long-term hospital care. In addition, the state will implement a pre-admission review system for persons applying for nursing home placement, and provide home and community-based services as alternatives for those who do not need nursing home care.

Neither the planning committee nor the state has set forth any time frame for meeting these goals. Governor Celeste, however, addresses the time issue in the conclusion of his forward:

"As with any strategic plan, some of the initiatives in this report can be carried out immediately — and, in fact, some already are being accomplished by this Administration. Others will require years of effort to complete. (This report) is the first step toward shaping a better future for all of our citizens. It represents our determination to set Ohio on a clear course of recovery, to encourage a spirit of public and private cooperation and to create innovative programs that will open new horizons for all of Ohio's citizens." **OSMA**

Karen S. Edwards is the Executive Editor of the **Ohio State Medical Journal.**

Control of Medical Emergency Services at the Scene of a Medical Emergency

BACKGROUND

Amended Resolution No. 39-82. *Protocol for Emergency Medical Services Personnel* (By Richard B. Fratianne, M.D., Cuyahoga County)

This resolution was referred to the OSMA Council and the OSMA Committee on Emergency and Disaster Medical Care. The Committee analyzed the subject of "Control of Medical Emergency Services at the Scene of a Medical Emergency" and determined there is no easy solution. A series of meetings were held by the Committee to draft and re-draft a proposed statement several times. In addition, during 1983, under the auspices of the State of Ohio Emergency Medical Services Advisory Council, OSMA has met with the representatives of the Ohio fire, rescue and EMS services concerning this matter. A draft was distributed to all these organizations via the State EMS Advisory Council Newsletter in February, 1984 and was discussed at the April 5, 1984 Advisory Council Meeting. The OSMA Committee reviewed the comments and finalized the document for submission to the OSMA Council. At the September, 1984 OSMA Council Meeting the following document was approved.

OVERVIEW

The extension of prehospital emergency care has become pretty well established with the citizens of Ohio. There is no question in trauma situations and acute myocardial infarction or life threatening arrythmias that arrival of Emergency Medical Technicians (EMT) within four to eight minutes after the onset of these critical events has made a difference in the mortality and morbidity rates. There are many other emergency health situations that have been helped by creating an ability of the community to provide well trained EMTs able to respond to these needs at short notice.

Currently, physicians and EMTs find themselves involved in controversies during interactions with patients in the doctors' offices, at nursing homes and at emergency street scenes. On one hand, EMTs are nonphysician personnel, highly trained in limited skills designed to counter specific features of medical conditions that kill and increase disability. They do this through specific treatments and procedures allowable only under the supervision of a licensed physician who by state law certifies their standing orders. This applies to the EMT-Advanced IV Technician, and EMT-Paramedic, who by Ohio Code are responsible for knowing specific information, becoming trained in specific procedures and providing emergency medical assistance in a limited basis. Since these procedures and medical acts are medical functions that directly apply to the practice of medicine, these EMTs are given civil immunity in order to serve the community without fear of being culpable of practicing medicine without a license. In the community sense, these EMTs are allowed to function as an extension of the physician who signs the standing orders under the supervision of the rules and regulations established by the Ohio Board of Regents, again, in direct compliance with the requirements of the Ohio Revised Code as passed by the legislature in 1976.

The problem pertains to the development of nonphysician personnel providing limited but highly trained medical assessment and procedures. These personnel usually become very skilled and well practiced in defibrillation, use of cardiac arrythmia drugs and treatment of shock due to trauma. Because of their limited role, they are bound by Ohio Code to not go beyond the requirements of the Ohio Code or they lose their civil immunity.

Physicians, however, have much more extensive training in the width and breadth of medical care. Physicians are licensed to practice medicine in the state, therefore, rendering a professional service which requires accountability and most probably will never have civil immunity. Many physicians, by reason of their specific area of medical knowledge, may or may not have highly practiced skills in CPR, recognition of ventricular defibrillation and other arrythmias, use of anti-arrythmic drugs, and provision of medical care for the patient in shock because of trauma.

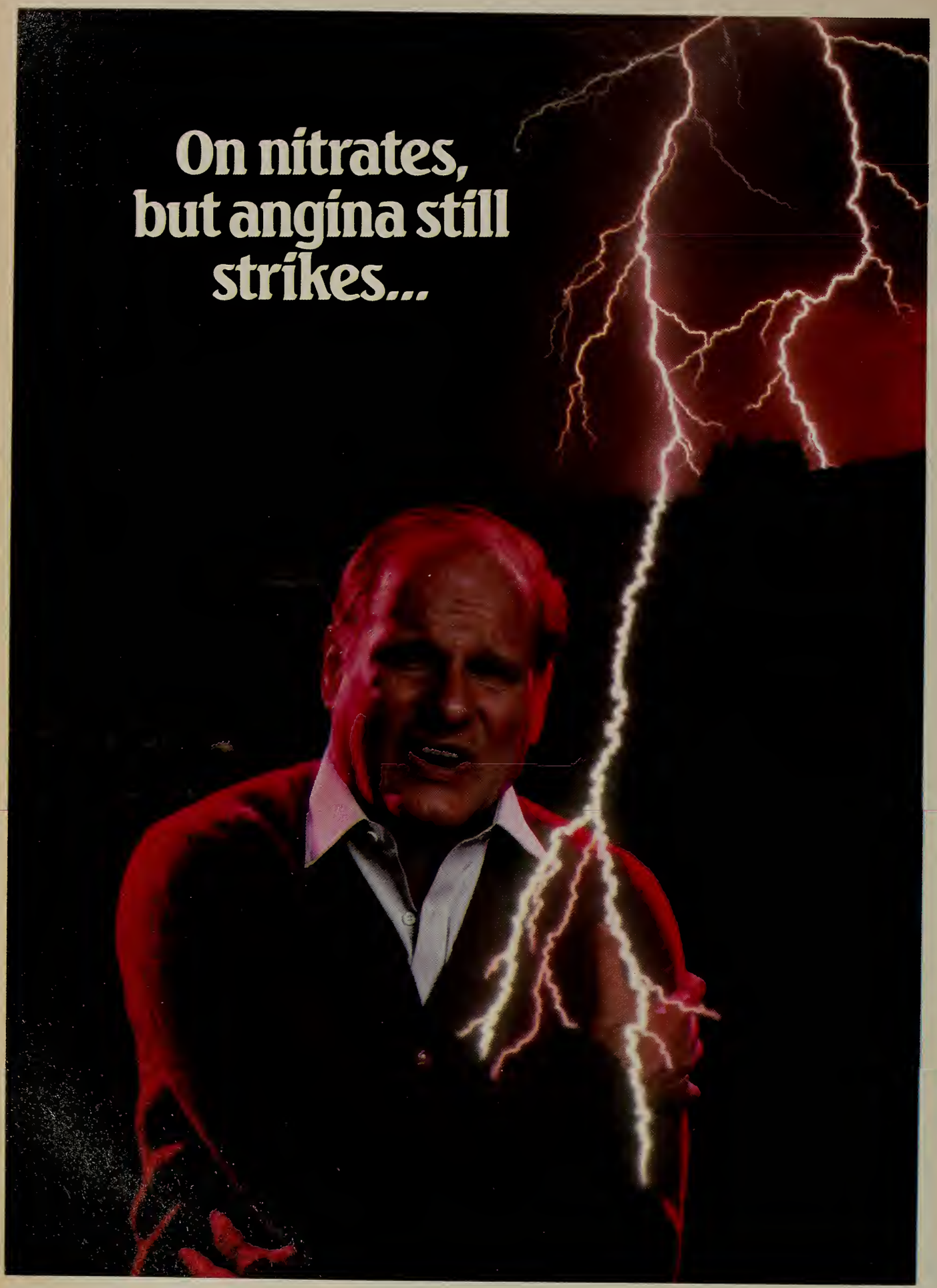
The emergency medical services personnel are instructed by their supervisors and their legal counsel that they may provide their functions to the public only in specific ways. They encounter frequently, in the prehospital setting, bystanders at the scene of an accident or health emergency who demand of them functions they legally cannot perform or actions they are not qualified to carry out. Indeed, a physician present at the scene with much broader medical knowledge may ask or expect the EMT personnel to do medical functions that are expressly forbidden to them. The problem grows larger in those cases where the EMT personnel are going to transport the patient to the hospital and the physician at the scene does not accompany the patient to the hospital. If anything was done before transporting the patient that goes beyond the specifically limited course of action allowed by the Ohio Code and rules and regulations of the Board of Regents, the paramedics have voided their immunity, if they accept and carry out those functions. This is especially true if the physician does not accompany the patient to the hospital, and the basic minimum requirements for EMTs to provide care to the patient during transport have not been met before transportation begins, although there may be very good medical reasons for this. What the physician determines that the patient needs for medical care and what the EMTs can do and must do may not match. This has led in some cases to EMTs ignoring physicians at the scene and in many cases, has established disagreement between the physician and EMTs during treatment at the scene.

It should be very obvious that physicians are the only proper group to provide medical supervision for these personnel, notwithstanding the need to recognize the qualifications and level of training of the individual physician involved. It also should be very obvious that the EMTs provide a natural extension of prehospital emergency care and as such have the patient's interest in mind, but no more than physicians do. Both groups are after the same goal: less mortality and morbidity among our citizens who sustain life threatening health emergencies before they reach hospital care. The OSMA, working in conjunction with the Ohio Emergency Medical Services Advisory Council, has established a dialogue with the fire and rescue services and all others who provide emergency medical services to the citizens of Ohio. Indeed, we have reason to believe Ohio may be one of the first states to tackle this problem in such a forum. It is through these meetings the following recommendations have been established, reflecting broadbase support from the OSMA Committee on Emergency and Disaster Medical Care and the prehospital emergency medical care personnel in the State of Ohio.

GOALS

There are two goals to be achieved with the adoption of this policy:

1. To improve the interaction between physicians and EMS systems.
2. To define the temporary relationships that occur between the physician and emergency medical services personnel at the scene of an accident or disaster.


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POLICY

In Ohio, medical control of EMS units is operating either by on-line: direct contact with base physician; or by written protocols and standing order: written and approved by a physician or physician advisory board. This is regardless of who arrives first at the scene, the physician or the EMS unit.

1. A physician (M.D. or D.O.) present at the scene of an emergency because of his/her license to practice medicine can control, within his/her scope of capabilities and skills, the emergency medical care delivered at the scene.
2. An EMT-A, Advanced EMT-A or EMT-P is protected by civil immunity when following the direction of a physician unless the actions of the EMT-A, Advanced EMT-A or EMT-P can be characterized as willful and wanton misconduct. Therefore, an EMT-A, Advanced EMT-A or EMT-P should cooperate and assist the physician at the scene who meets the requirements outlined in #3.
3. A fully licensed physician who wishes to assume control of the medical emergency care of the patient must agree to the following:
   a) Provide the EMT-A, Advanced EMT-A or EMT-P satisfactory proof he/she is a physician. (State Medical Board license card preferred.)
   b) Sign his/her orders given. (Means taking legal responsibility for the medical care of the patient rendered under his/her direction.)
   c) Recognize the following:
      1) EMT-A, Advanced EMT-A or EMT-P can function only within the scope of his/her training and statutory authority.
      2) Any orders given beyond the training and/or authority of the EMT-A, Advanced EMT-A or EMT-P, or conflicting with his/her training or authority requires the physician to be responsible for assuring adequate supervision of the medical care provided during treatment and transport. This means the physician will accompany the patient to the hospital unless it is a multiple casualty incident or disaster situation and he/she deems it necessary to stay at the scene.
      3) The physician at the scene must agree to communicate with the base station physician as soon as medically feasible if radio

communications to a base physician exist. The base physician can re-assume control at his discretion. In the case where the physician arrives on the scene after the paramedical personnel, if the base physician does not relinquish control, the paramedic follows the base physician's orders.

EXPLANATION OF POLICY

1. Since a physician has a license for the practice of medicine, it is appropriate for a physician to become involved with administering medical care at the scene of a medical emergency.

An EMT-A or Advanced EMT-A provides Basic Life Support functions as defined by Section 4731.82 (A) & (B) in the Ohio Revised Code. Any licensed physician (M.D. or D.O.) can assume control of the medical care of the patient at the emergency scene and require the cooperation and assistance of the EMT-A or Advanced EMT-A on the scene.

A physician who assumes control over the activities of the EMT-A or Advanced EMT-A may return medical control to the EMT-A or Advanced EMT-A so long as the level of care being provided does not exceed the training and/or protocol of the EMT-A or Advanced EMT-A.

If a level of care beyond the training/authority of an EMT-A or Advanced EMT-A has been established, or the medical direction given conflicts with the protocol, then the physician at the scene shall be responsible for assuring adequate supervision of the medical care until that supervision/control is transferred to either a base station physician or receiving hospital personnel.

2. A paramedic (EMT-P) provides Advanced Life Support functions as defined by Section 4731.82 (C) of the Ohio Revised Code. These functions can be performed in conjunction with a cooperating M.D. or D.O. or physician advisory board. A "cooperating physician" may be a physician at the scene of a medical emergency who can control/supervise the activities of the EMT-P within the scope of the EMT-P's training and authority and require his/her cooperation and assistance.

The physician who has assumed control at the scene is responsible for assuring adequate supervision over the activities of the EMT-P until supervision/control is transferred to either a base station physician or receiving hospital personnel. If a level of care beyond the training and/or authority of the EMT-P has been

continued on page 846

The Committee on Emergency and Disaster Care

The Ohio State Medical Association gratefully acknowledges the work of its Committee on Emergency and Disaster Medical Care, whose time and effort resulted in the formulation and wording of this new policy.

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Solo, Partnership or Corporation:

Which Practice Is Best for You?

By Karen S. Edwards

At some point in your career, you may be thinking about changing the way you do business.

Certainly there is more than one way to practice medicine . . . but whether the traditional form of sole proprietorship, group practice or the more structured, corporate form will be your cup of tea will depend to a large extent upon your needs and the manner in which you prefer to conduct business.

"In a sole proprietorship, you are in business for yourself. That's the plus side," says Marlene Frank, an attorney with Porter, Wright, Morris and Arthur, a law firm located in Columbus. Frank recently spoke to a group of medical residents attending a seminar entitled "Starting Your Practice," co-sponsored by the American and Ohio State Medical Associations.

"Usually a solo practitioner has no set salary. He or she takes care of all the expenses and keeps whatever is left," says Frank, who points out that the final sum may be bad or good, depending on how business fared during the year.

"Whatever the income, however, it must be reported on individual tax returns, so the physician has to be careful that all business expenses are properly kept and recorded," says Frank.

Those who consider record-keeping a nuisance are likely to find this particular aspect of solo practice its biggest drawback. But, according to Frank, there is a bigger one yet.

"A solo practitioner has unlimited liability. If anything goes wrong in the practice, he or she is liable — even personally liable," says Frank, which means that, in a malpractice suit, the physician's personal property, as well as his or her practice, can be in jeopardy if things go wrong.

"All partnerships should have a written agreement upfront which details how the partnership is divided, how liability is to be handled and so forth. Anyone 'buying into' a partnership needs to be especially careful about getting as much information down on paper as possible."

In a partnership arrangement, liability can also be a touchy issue.

"If the partnership has been designated as liable in cases of malpractice, then no matter what your percentage of partnership might be, you will be sharing the liability of your partner's malpractice suits. That's why it's so important to choose your partners carefully," Frank says.

Partnerships can be as small as two physicians or as complex as a large group of assorted specialists. All, however, share expenses — and profits — and generally file an informational tax return with the Internal Revenue Service.

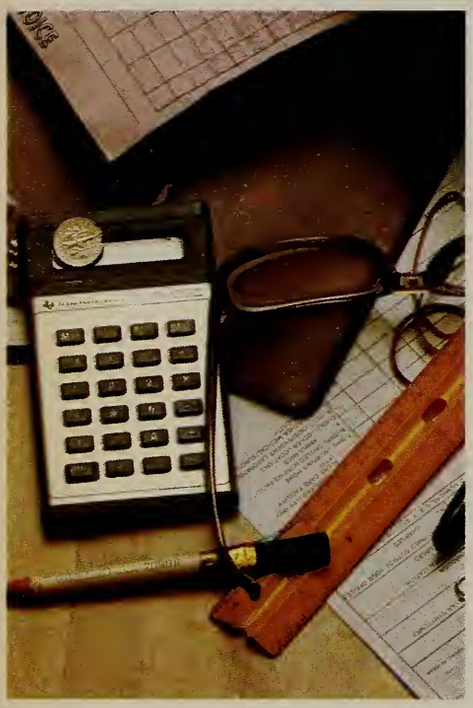
"All partnerships should have a written agreement upfront which details how the partnership is divided, how liability is to be handled and so forth. Anyone 'buying into' a partnership needs to be especially careful about getting as much information down on paper as possible. Then, that contract should be reviewed by an attorney and an accountant," warns Frank.

Many of the problems which arise in partnerships could be avoided if these steps were taken, she adds.

"Some partners will tell a physician 'if you come work for me, I'll make

Solo, Partnership or Corporation?

continued



"You would do well to check with an advisor — an attorney or accountant — before you do decide to set up a corporation. You may find it's not worth the trouble."

you a partner as soon as the practice size doubles.' But that's so ambiguous. What does doubling in practice size mean? Doubling in patients or doubling in money brought in? You need to define each agreement made, then reduce it to writing."

That advice becomes even more important when a physician, partnership or group decides to incorporate.

"Corporations can be very complicated, expensive things to set up," says Frank, explaining that, legally, corporations are separate entities, with a number of state laws governing their existence.

"Each corporation needs a board of directors which, in turn, elects officers to run its day-to-day activities.

"Too," she continues, "corporations must get involved with annual meetings and annual reports . . . there are a number of extra details that need attention when establishing this type of practice," she adds.

Generally, the corporation — not the physician-employee — is the taxpayer in these arrangements, and the corporation is usually liable for its own debts. In other words, the personal assets of the corporation's shareholders (its physician-employees) cannot be touched in malpractice settlements (unless, of course, a home or other personal asset was used as collateral in setting up the corporation).

"Of course, one of the advantages of corporations is the fringe benefits it can offer its employees," says Frank — group term life insurance, for example, and medical reimbursement.

"One of the reasons many corporations were formed in the past was to create retirement plans," says Frank, and these are still a very viable benefit of the corporate form of practice.

"The corporation or company will set up a plan whereby it makes contributions to an employee's retirement — usually a percentage of the employee's salary. The company will then receive tax deductions for the amount of money it is contributing to the plan, and the employee-physicians pay tax only on that share of income he or she receives."

A physician making $125,000 per year, for example, can have $25,000 put into a retirement plan and pay taxes only on the $100,000 he or she receives as salary, she explains.

"If you begin this plan when you are young enough, you can see how you can accumulate quite a retirement nest egg," she says, but she warns that you will have to pay tax on the sum you withdraw when you retire.

Until recently, corporations were the only forms of practice that could establish this type of retirement plan. Sole proprietorships and partners had to use a Keogh plan, if they used one at all. "Congress has changed that so now any practice can shelter up to $30,000 a year in a retirement plan," she says, so forming corporations expressly for the purpose of establishing a retirement plan is no longer necessary.

"You would do well to check with an adviser — an attorney or accountant — before you do decide to set up a corporation. You may find it's not worth the trouble."

Have an attorney and an accountant review any employment contracts before joining a corporation as well, she advises.

"Check what benefits they offer. An offer of a $100,000 salary may sound more tempting than a $90,000 salary, unless you consider that the lower salary includes a $25,000 benefit package which the higher one does not include." Check, too, for the kind of terms in each contract.

"The biggest problem we run into is with the 'not-to-compete' covenant included in most corporate contracts. Most employers want some assurance that if a physician were to leave the corporation, he or she would not take all the business away," Frank says.

So, a section is usually written into the contract which states that should the physician decide to leave the corporation, he or she would not be permitted to practice within close proximity of the corporation for a given period of time.

"The covenant is enforceable if a reasonable time and distance have been specified — for example, that the physician could not practice within a five-mile radius of the corporation for two years."

Be careful, though, Frank says, about any unreasonable terms that may be put into the contract — because they can also be made enforceable.

"The court can blue-pencil any doctrine to make unreasonable terms reasonable, and thus enforceable," she says.

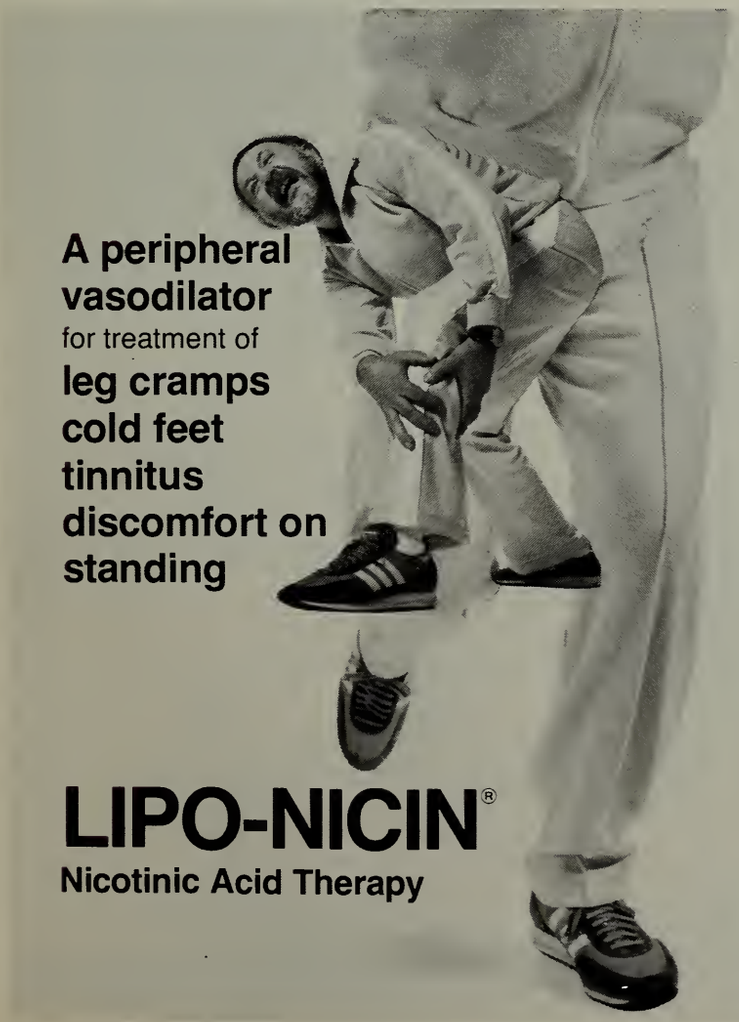
Liquidating a corporation can be as difficult — if not more so — than setting one up, and "you can incur taxes if the corporation is worth more than the amount of money you may have put into it," she adds. Therefore, she advises against liquidating corporations and takes the matter one step further.

"Don't set up a corporation unless you plan to keep it," she says.

In fact, Frank suggests that physicians may wish to begin their practice as sole proprietors, then move on into partnerships or corporations as their practice grows — and their need to shelter income increases.

"But I wouldn't advise starting your practice by forming a corporation. It's just too much trouble," she concludes. **OSMA**

Karen S. Edwards is the Executive Editor of the Ohio State Medical Journal.



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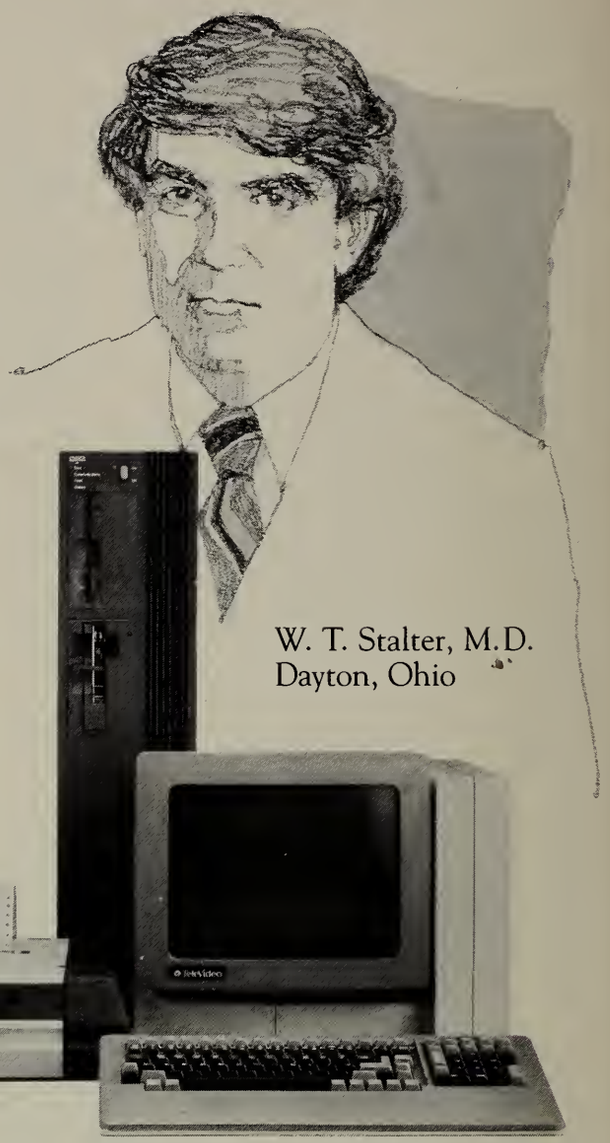
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Unpaid Accounts and How to Cope with Them

By Ira A. Abrahamson, Jr., MD

One of the more unpleasant aspects of practicing medicine is the "Accounts Receivable" file. Regardless of the doctor's good faith, there are often a number of patients who don't or won't pay their bills. It is for this reason this article was prepared — to provide some insight into why accounts remain unpaid.

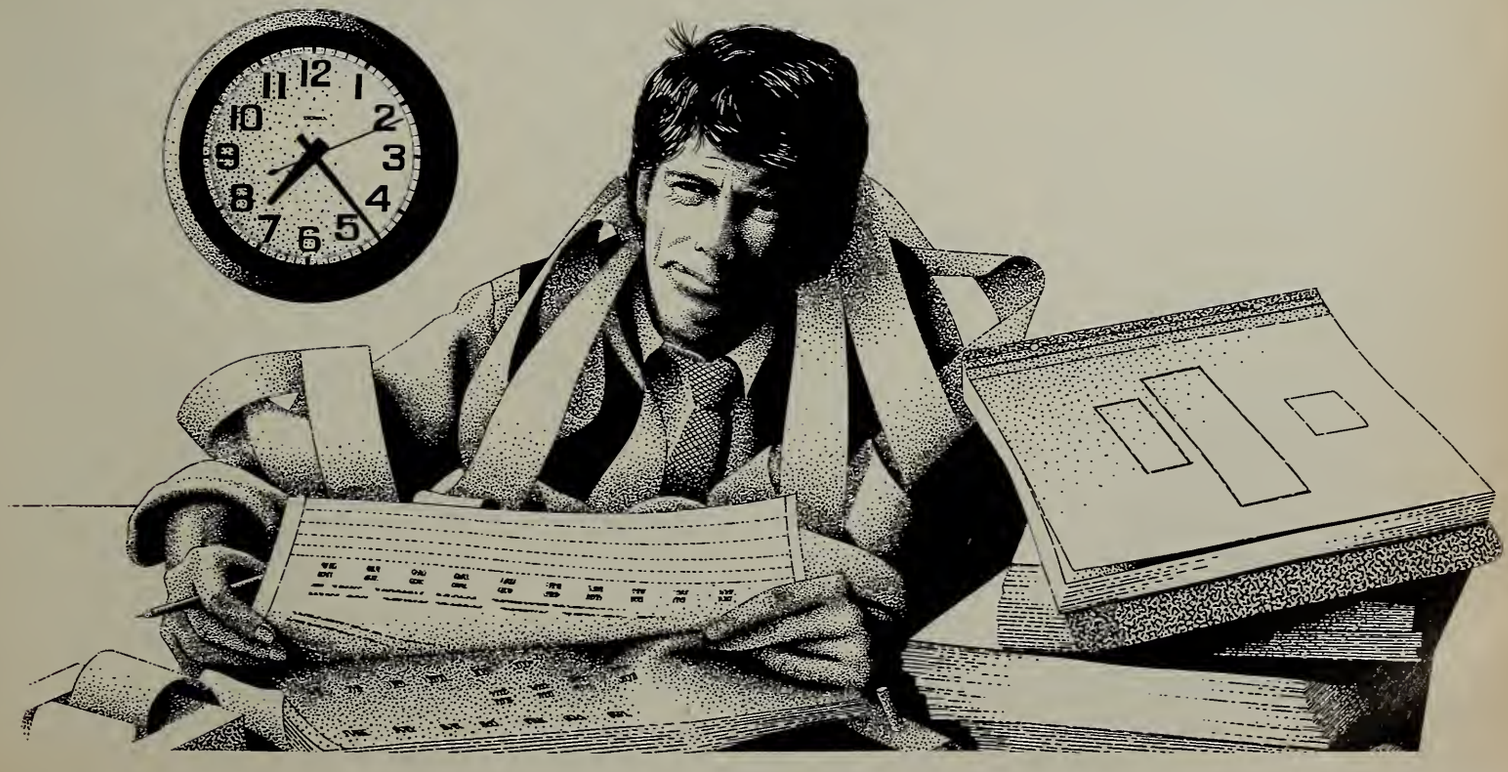
It should be stated from the onset that the greatest majority of our patients do pay their bill for services rendered (almost 90%) — leaving a small reservoir of outstanding debts on the books. Good medical service, patient rapport, and a healthy measure of satisfaction are the primary elements for a good collection percentage (ratio). Before scheduling patients, give them an idea of how much an examination, treatment, or surgical procedure is going to be.

At the first visit, ask the patient "who is responsible for paying your bill?", then, obtain correct address, telephone number (office and residence), place of employment, referral reference, insurance companies, Medicare number, I.C. number, etc.

Upon completing an office visit, guide the patient to the front office receptionist and tell him or her, "Your fee for today's examination or treatment is $_____." Encourage the patient to pay on the spot (cash or check) or to mail the fee in a self-addressed envelope, "in order to save bookkeeping, postage, and mailing expenses."

When surgical cases are scheduled, give the patients a ball-park figure of costs before having the procedure performed. The office manager could present the patient with a payment schedule, covering a period of time in which the bill can be paid. Apprise the patient that charges are made with him or her — not with an insurance company which may cover only a percentage of the bill. Instruct your patients that your office will cooperate with them in any way — filling out all insurance papers or forms at no extra charge. Explain to them that if checks are paid to you by the insurance companies, any overpayment will be refunded back to them by your office.

Regardless of how good your collection ratio is, there is always a reservoir of outstanding debts that remain. Why do these people not pay



their bills? Following is a list of the most common reasons for this backlog, and how one might cope with each situation.

1. The patient who feels that the "doctor has too much money and doesn't need any more."

Remedy: Many doctors contribute some of their spare time and skill to charity clinics, but their offices should be places to provide their own livelihoods. This should be established by either the doctor or the receptionist before the doctor sees the patient, and some arrangements should be made with the patient, so that he or she can make either weekly or monthly payments.

2. Since most doctors do not charge interest, provide penalties, or carry charges on the balance owed, patients assume a casual attitude about their financial obligation.

Remedy: Encourage payment of the bill before the patient leaves the office. If this is impossible, then half or partial payment should be made. Self-addressed envelopes should be provided by the receptionist to encourage patients to mail in the balance of their bill immediately.

3. When the patient has completed his/her examination or treatment and is presented with a statement, he/she may feel that the charges were excessive, or an overcharge has been made.

Remedy: It is advisable to try to explain the fees to the patient before he/she is examined or before any surgery is performed in order to prevent this problem. However, if the patient feels that the fee is too high, then explain your charges in detail, and if necessary, make an adjustment or collect a partial payment of the bill.

4. There are some patients who were not going to pay anyway, giving a phony name, address, telephone number, and reference.

Remedy: If possible, check the references a patient gives the day that he or she is in your office. However since it is frequently impossible to do this, you may have to simply turn the patient's name over to a collection agency.

5. Family problems are a big factor. One situation concerns lack of employment — the patients' husband or father may have been laid off his job, is not working, and therefore is receiving no income.

A second family problem is the divorced couple. The wife thinks that the husband should pay the medical bills, and the husband thinks the wife should pay not only her bills but those of the children as well.

Remedy: It is suggested that on the first visit you try to establish who will be responsible for the payment of the bill before the patient is seen or before he/she leaves the office. Try to establish a specific collection schedule with the person who brought the patient into the office, and make them responsible for seeing that some payment is made.

6. Some patients don't have any money, yet they are unwilling to go to a clinic.

Remedy: The fee should be established by the office manager before the patient is seen, so that unnecessary charges will not be made. It is also advisable to try to establish some kind of payment schedule with the patient while he or she is still in the office.

7. Another source of payment problems involves industrial cases. In an emergency that may or may not have happened at work, the patient feels that the company should pay the bill, while the company feels that the patient should pay his/her own bill. The doctor treats the patient, and is left holding the bag, receiving no compensation from either party.

Remedy: If possible, try to establish on the first visit whether it was an industrial injury or not, and who will be responsible for the bill. Obtain an I.C. number from the individual or company. If it is uncertain, then it should be established that the patient should agree to pay the bill with the understanding that if the company does pay the bill, the patient will be reimbursed. It is recommended that the company give the employee a pink or white slip to prove that it was an industrial case on the initial visit with the doctor.

8. Time delay. The patient may get tired of waiting for the doctor or feel that when he or she was seen by the doctor, the doctors' full attention was not given. Then, if the slightest problem occurs or the patient is not satisfied, he or she may blame the doctor and not pay the bill.

Remedy: Frequently the remedy for this type of problem is to try to slow

Encourage payment of the bill before the patient leaves the office. If this is impossible, then half or partial payment should be made. Self-addressed envelopes should be provided to encourage patients to mail in the balance immediately.



down and "give the patient 100% of your undivided attention," no matter how busy or rushed you are. Before the patient leaves your office, ask, "Do you understand your problem and the treatment, and are there any questions you want to ask?" This usually will win patients back, and give them a vote of confidence in your ability and interest. Eliminate all interruptions and telephone calls until you are finished with the patient you are examining, unless it is an emergency.

9. Dissatisfaction with the treatment results, medically or surgically.

a. The patient may seek a second opinion, and if the second doctor treats him or her satisfactorily, he or she may feel that it is unnecessary to pay for the first doctor's services.

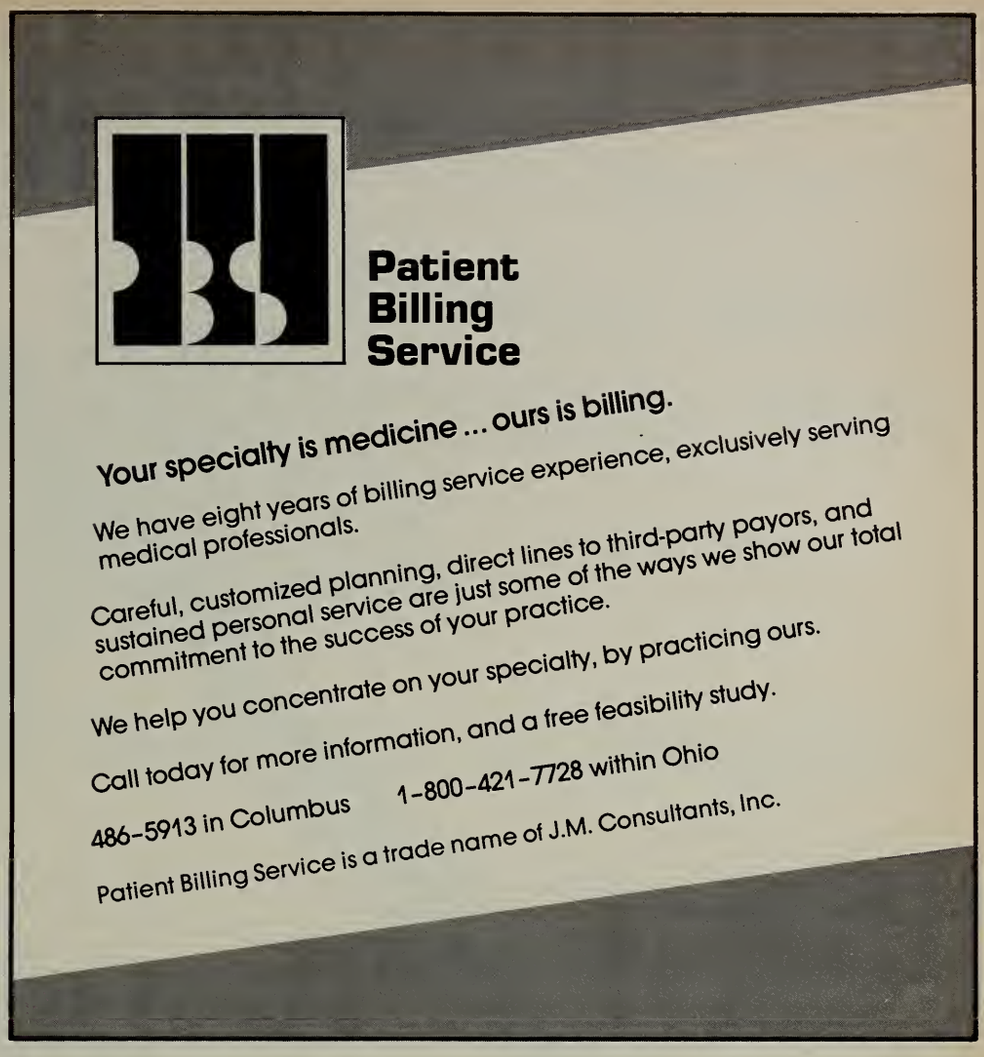
b. When surgery was performed, the results produced may not be what the patient anticipated or expected. So he or she doesn't pay all of the bill.

Remedy: Tell the patient to return to the office for gratis, and the doctor will try to correct the problem. *Taking time to explain problems to the patient* is important and may save undue embarrassment or dissatisfaction. Having the patient return to the office will also give you an opportunity to talk to the patient face to face and arrange a payment schedule or provide other necessary treatment.

COMMENT

It is recommended that, if at all possible, the receptionist should try to collect the fees for treatments or examinations from the patient before he or she leaves your office after the first visit. This is especially true for all new patients. It is suggested that if the patient cannot pay on the spot, they be given a self-addressed envelope in which to mail their payment. Surgical fees should be established and recorded before the surgery is performed, and arrangements should be made to have the bill paid by a certain period of time. After 60 days, an attempt should be made to go after the patient by personal telephone calls, and to try to collect all or some of the outstanding accounts. Personal telephone calls by the office manager, bookkeeper, or nurses are more effective than sending out letters requesting payments. A personal telephone call will frequently discover why the bill has not been paid. Mailed letters or repeated statements with "first notice," "second notice," and "final notice," often remain unanswered. Accounts over 90 days are notoriously difficult to collect because the patient psychologically does not relate the charge to the services performed. **OSMA**

Ira A. Abrahamson, Jr., MD, practices in Cincinnati, Ohio.



Radiological officers named for 1984-85

The following persons were elected officers for the 1984-85 term at the Ohio State Radiological Society Annual meeting: LAWRENCE G. THORLEY, MD, Amherst, president; JAMES D. CURRY, MD, Mansfield, president-elect; CHARLES F. MUELLER, MD, Columbus, secretary; EDWARD F. MORRIS, MD, Barberton, treasurer; KONRAD F. KIRCHER, MD, Dayton, immediate past president.

Depression can be serious

General practitioners are being urged to recognize "the potential chronicity of depressive disorders" and to refer seriously depressed patients to "intensive treatment and psychiatric consultation" in a recent issue of the *Journal of the American Medical Association (JAMA).*

According to the report, researchers at the Massachusetts General Hospital in Boston discovered that 20% of the 97 chronically depressed patients they studied remained seriously ill for two years.

"The rate of recovery was highest in the three months after entry into the study, with a notable decrease in rate after one year," the researchers say. However, "Most patients who did not recover had severe depressive symptoms throughout the two years of follow-up."

The researchers also discovered that married subjects had a greater likelihood of suffering long-term depression than single, divorced, separated or widowed persons, although the unmarried were more likely to have an episode of depression.

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Is Your Office Ready for a Computer?

By Susan Porter

Are your file cabinets so crammed with patient records that you can no longer open and shut the drawers?

Do the insurance claims you submit for your patients have a way of coming back six months later stamped *"INCOMPLETE"?*

Are you and your patient constantly running into your partner and his or her patient in the same examining room?

Are you still wondering if that EKG you purchased a year ago is paying for itself?

If the answer to more than one of these questions is "yes," it may be time you overcame that potential case of computer-phobia and moved "computerization" a little higher on your list of office management priorities.

According to recent surveys, approximately 25% of doctors' offices, nationwide, have already experienced the often unnerving and sometimes tremendous task of computerization. Another 50% are expected to do so over the next three years, says Christopher D. Barr, an administrative assistant for Physicians Administrative Corporation of Ohio (PACO), an affiliate company of the OSMA which specializes in medical computer systems for physicians.

The 50% "includes both purchasing in-house systems and contracting with outside companies for computerized billing services," Barr explains.

The reason for this great influx of doctors into the computer marketplace are many, beginning, of course, with the development of the minicomputer and the even smaller microcomputer. The latter has made it possible for even the solo practitioner with a limited number of patients to purchase and utilize a system.

"A year ago, automation for the single physician was not all that necessary . . . (but) every doctor today needs to take a good hard look at automation."

Until recently, however, the cost-effectiveness of incorporating even a microcomputer into a small practice was questionable.

"A year ago, automation for the single physician was not all that necessary," says Peter Neola, regional manager of Computer Terminal Services, Inc. (CTS), a company with regional headquarters in Cleveland which specializes in medical management systems.

"What's happening today in the medical industry, however, is that insurance companies are pushing harder and harder to have insurance claims submitted electronically," Neola says. "Every doctor today needs to take a good hard look at automation."

According to Barr, physicians have been able to submit their Medicaid claims "tape-to-tape" or electronically (directly via the computer) for the past three years. Medicare has been encouraging physicians to use a similar paperless claims submission for the past two years, and approximately 18% are now submitted that way, says Tom Miller at Nationwide.

Other large insurers have also become involved. For example, Ohio Medical Indemnity Mutual, the Blue Shield Plan in Worthington, has developed, in cooperation with IBM, the Ohio Provider Entry Network (OPEN), which allows claims to be filled with Blue Shield electronically. The program can also be used to generate data for standard American Medical Association claim forms, says Barbara Bonfont of OMI, and can produce a summary report of the

Is Your Office Ready for a Computer?

continued

day's activities to assist in monitoring claims.

By the first of the year, physicians throughout the state also will be able to use the system for direct entry to Medicare claims. "Our goal is to enable the physicians using the system to be able to submit as many insurance claims electronically as possible," Bonfont says.

Electronic billing cuts down costs for the insurance companies, by eliminating the amount of paperwork the company handles. The physician, in turn, benefits from the faster processing with "tremendous cash-flow savings," says Cedric D'Mello, office manager for Computer Office Services, Inc. (COS), in Bedford Heights, another company which specializes in computer packages designed for physicians. And a good computer system will generate insurance forms automatically — faster and more accurately than filling out forms by hand, he adds.

While the filing of insurance claims is a key use of the computer in the physician's office, it is by no means the only reason to pack up those office files and folders and replace them with a terminal, keyboard and printer. A computer system of your own may not be the answer for you, at all.

"Many physicians prefer to have someone else handle their billings and insurance claims," says Laura Dalton, a computer operator for Herman and Agnes, a CPA firm in Akron that will assist physicians in computerizing their offices — or will handle those services for them.

"Computers may be used by doctors for payrolls, statements, check stubs and balance sheets," she explains. "They can also tell you how much money you're taking in and how much money you're paying out, or you can continually analyze your practice for changes."

But she continues, "Most of our clients are so busy, they don't really have time to keep on top of things. And if there is a breakdown, they're in trouble. They don't have time for those kinds of headaches."

Thus, Herman and Agnes and other companies like it will provide computerized services for their customers, ranging from patient billings and insurance claims to payroll services and complete monthly financial reports. The latter is generally a four to eight page document summarizing the practices' income and expenses, assets and liabilities.

"As long as they are getting the information they need — that's all some doctors want to worry about," she says.

Computers may be used by doctors for payrolls, statements, check stubs and balance sheets. They tell you how much money is coming in and going out . . .

However, there may be some disadvantages to an out-of-house system, others in the computer field point out. These include secrecy and confidentiality," says D'Mello. "You have more effective safeguards over your data when it's in your own system," he says. And following your initial capital outlay, "it's generally less costly for you to handle your own affairs, than it is to pay someone else to handle them for you," he adds.

D'Mello also points to a time consideration — if your accounts are regularly shipped out, access to the data you need may be delayed. "When it's on your own system, your reports are always available at your fingertips," he says. "This allows for easier and better decision making, and that means better management."

In addition, a computer system can reach far beyond a billing and bookkeeping service. A new book issued recently by Harcourt Brace and Jovanovich titled *Computers for Medical Offices* lists over 700 different medical office computer capabilities; these range from production of charts of laboratory results to labels for recalling patients for follow-up visits or check-ups.

"In selecting a computer system, your goal from the very beginning should be to go beyond merely obtaining a 'good' system," the book says. "Too many medical practices have what they consider to be good systems, yet they fail to realize the full benefits of computer power. . . . When you are considering different systems, you should keep in mind not just the basic benefits that computers provide, but the full range of advantages and services that they can provide to your medical practice."

What Computers Can Do

According to Barr, the uses of the computer in the doctor's office are as many and varied as the kinds of practices using them.

"One reason computers are becoming so popular in medicine," he says, "Is that we are seeing a big trend toward group practices, and often the physicians in those practices are paid according to production. The computer can keep ongoing production totals, since it tracks billings and payments automatically."

A good computer system can also help the physician get a better handle on his or her patient load by sorting information according to demographics. The information generated may, in turn, be used in efforts to study or recruit patients in certain geographic areas or age groups.

"Especially in the rural areas and small towns, physicians want to know where their patients are coming from and in what areas they are losing patients," Barr says.

In addition, "If you're a specialist, you can determine which physicians are giving you referrals, and which ones are not," he adds.

Another advantage, says Barr, is that the computer can tell you what kind of "services rendered mix" you have. "You may find out you have an

expensive piece of equipment that is hardly being used, and you may want to let more people know that service is available," he says. In addition, the computer can tell you which of the services you provide bring in the most income — and which ones may actually be costing you money.

Most of these analyses can be made simply by making better use of the information that has always been included in your office files — but that would be much too difficult or time consuming to sort out and categorize by hand. "The computer allows the information you normally keep to fall into a number of different 'files' — you can retrieve it in any number of a different ways," Barr explains.

Still, the major use of the computer in the doctor's office is to help speed up and make more efficient traditional billing and bookkeeping tasks: keeping patient records, recording visits and procedures, processing insurance claims, billing patients and scheduling and recalling patients for appointments. It can also contribute to better office management: ordering supplies and equipment, scheduling examining rooms and tracking and paying employees.

What can result, says *Computers for Medical Offices*, is reduced labor hours, improved patient services, better cash-flow management, increased productivity and efficiency, and better practice management and marketing decisions.

Still, before you decide to go out and buy a system — or determine that it would be cheaper and easier for you to continue keeping records by hand or hire an outside service — an appointment with your accountant is advisable. A good accountant can help you to decide not only if computerization is economically feasible, but also if it's "reasonable and justifiable," in Barr's words.

For instance, if you're an older physician who is gearing down your practice for retirement, it may not be worth the time, effort and expense to install a computer system. "But it really depends on the individual physician," says Barr. "If you're planning to sell your practice when you retire, it could be worth a lot more if it's computerized."

Selecting a System

Once you have decided that computerization is right for your practice, there are a number of steps you can go through to help insure you get the right system for your needs.

The first step is to decide what it is *you* would like a computer to do in *your* office. If insurance claims processing is your primary consideration, put that at the top of your list. If you'd also like it to handle some practice management functions or word processing, put those items on your list, too.

Check with colleagues whose offices are already computerized . . . ask them what features they wish they had incorporated into their systems.

Don't be afraid to check with colleagues whose offices are already computerized — not only to ask them the pros and cons of their systems, but also to ask them what features they wish they had incorporated into their systems.

Secondly, you will want to survey the computer marketplace for the software packages (the programs that actually run the system) that best accomplish the tasks you have in mind, along with the hardware (the equipment, itself) needed to run those programs. *Computers for Medical Offices* lists over 130 vendors who now specialize in medical software and hardware, and new ones enter the marketplace everyday.

"Hundreds of vendors are now trying to sell computers to physicians," says Neola. Therefore, you will want to make sure you are dealing with a reputable company, and preferably one with a good track record in dealing with physicians. Again, colleagues may be your most valuable resource.

While some companies will offer to design software programs custom tailored to fit your individual needs, these will generally be much more expensive than purchasing a ready-made program designed for physicians. If you choose the latter, however, make sure the program is flexible enough that changes can be made, and that it can be updated periodically to grow with your practice.

"Physicians are all in the same business — the practice of medicine," says Barr. "But they all do it a little differently. You want to buy a computer system that fits your practice — not change your practice to fit a computer system."

The software programs you select will, to a large degree, determine what hardware equipment you will buy, since software programs are designed to run on a particular hardware set-up. For example, PACO's Medical Computer System modules can be run on either the TelevideoTS 803 personal computer (for the smaller office) or the Charles River Data Systems equipment (for larger offices). The CTS Medical Management System uses WANG hardware, while the Physician Billing System designed by COS is designed to operate on an IBM-PC XT microcomputer. And Ohio Medical Indemnity Mutual's OPEN program for electronic billing is designed for use on an IBM/PC.

Your choice of software programs, however, is only the beginning of determining what hardware you will need to make those programs work. Other key considerations are memory (the amount of data that can be stored on the computer) and speed, or the time it takes to process the information. You will also need to determine the number of terminals and keyboards your office will require along with the quality of the printer

Is Your Office Ready for a Computer?

continued

and the type of modem (telephone hookup) you need. Your requirements for these will largely depend on the size of your office and the type and number of functions you want the system to perform.

One way to help determine the size of the system you will need is to contact a number of vendors in your area — by mail, phone or in person — explaining to them the size of your practice (number of partners, patient base, average daily appointments, etc.), and the functions you wish the computer to perform. Some, like PACO, will come to you.

"We will go to the physician's office, study his or her needs on site and then determine the best system to fit that office," Barr says.

He then suggests getting bids or proposals from several vendors, and comparing notes — not only on the quality and price of the merchandise offered, but also on the size and the flexibility of the system.

It is also important to check what type of training, installation and services are offered by the vendor — and who will provide those services — the local company who sold you the system or the manufacturer of the equipment? Is the service offered by an authorized dealer? If not, it could take twice as long to get parts needed for repairs, Barr warns.

In addition, look for a guarantee regarding "downtime" — some companies will promise service within four hours of a call; others may take 24-hours to arrive on the scene. "And when your computer is down, your practice is down," says Barr.

And finally, you may want to consider a company that offers a "trade-up" agreement, so that if you should add another partner or open a satellite office, you can trade in your smaller system for a larger one.

Getting on-line

Once you have selected your computer system and have negotiated a purchase agreement and service contract that fits your needs, the real work of computerization can begin.

Even under the best of circumstances, implementation of a computer system can take from several weeks to several months, depending on the amount of time you wish to devote to the process. While some prefer to enter all of their files into the system up-front, others recommend a more gradual process. Barr suggests that data be put into the system "as each patient comes in the door."

Because today's computers are so "user friendly" or easy to use, no new or additional staff should be necessary for the transformation, although each staff member using the system will need to be trained. If you are planning to add staff members, anyway, "don't choose someone who's afraid of the word 'computer'," Barr suggests, although no special computer experience is necessary, since each system operates differently.

Check what type of training, installation and services are offered by the vendor, and who will provide those services . . .

Eventually, your computer system should save both you and your staff a lot of time. But don't expect miracles. The one thing a computer system cannot do is think, nor can it make decisions for you. It can only give you back that information which you feed into it — and the quality and accuracy of that information depends on who's doing the feeding.

Still, with the right computer system, adequate training and support from the vendor and a competent staff, you can look forward to spending a lot less time with papers, and a lot more time with patients. **OSMA**

Susan Porter is Assistant Editor of the **Ohio State Medical Journal.**

Emergency Medicine

continued from page 833

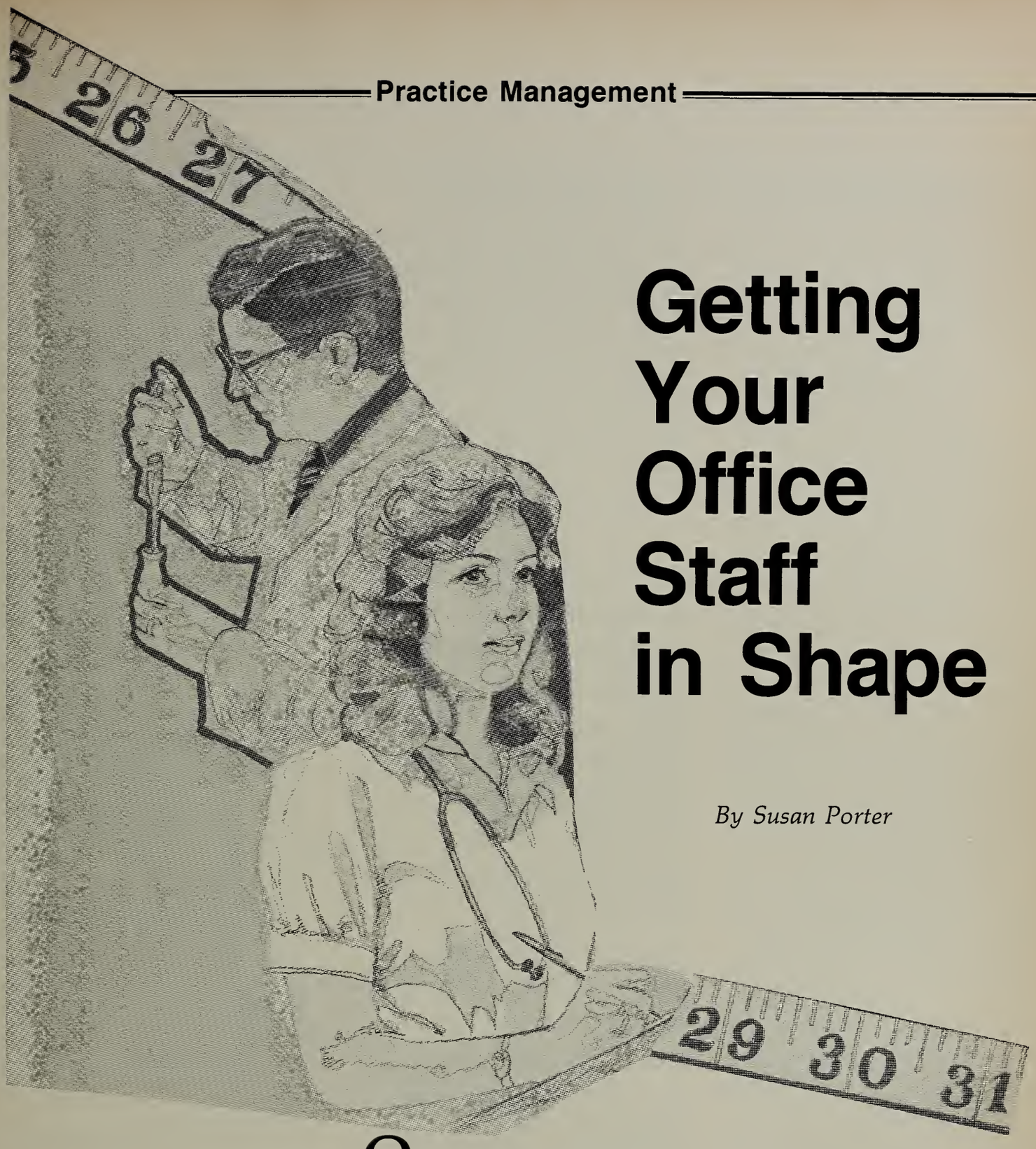
established, the physician is responsible for assuring adequate supervision of the medical care during transport.

When an EMT-P is operating only by written standing orders prepared by a medical advisor or advisory board, a physician at the scene can assume control of the EMT-P and may supercede the written orders and require the cooperation and assistance of the EMT-P. After assuming control, within the physician's scope of training, he or she can transfer care of the patient back to the EMT-P if the care has not gone beyond the EMT-P's level of training and/or authority, providing the EMT-P agrees to re-assume control. If a level of care goes beyond the EMT-P's level of training and/or authority, the physician who assumes control is responsible for assuring adequate supervision of the medical care during transport until supervision/control is transferred to either a base station physician or receiving hospital personnel. **OSMA**

Next month in:

THE Ohio STATE Medical Journal

Is Ohio heading for another MALPRACTICE CRISIS?



Getting Your Office Staff in Shape

By Susan Porter

One of the greatest assets of any medical practice — be it a solo family practitioner, a medium-sized group of specialists or a large clinic — is a competent, well-trained office staff; a dedicated, hard-working group of people who answer your phones promptly, greet your patients with cheer, schedule your appointments proficiently and never interrupt you when you're with a patient.

The best public relations campaign and the most competent medical care you can give will slowly but surely be undermined by an unfriendly, inept staff. So if your patients are constantly complaining about the treatment they're getting *outside* the examining room — or worse yet, if they're not coming back at all — it may be time you took a better look at what your office staff is doing — or not doing — for you.

"If you're having a hard time getting a good appointment schedule down, or if your accounts receivables are not being collected, it may be a red flag going up that you need more help," says Maury Kulwin, a program administrator for the American

Medical Association (AMA) who recently discussed employee selection and management at a "Starting Your Practice" seminar, co-sponsored by the OSMA and AMA.

And the problems may not all be with the staff. "If you're having trouble keeping a good staff — if people are not staying with you — you may need to consider what it is *you're* not doing right," Kulwin says.

One good way to keep abreast of what's going on in your office is to hold regular monthly staff meetings, says Linda Jesseph, a professional consultant with Medical Consultants Unlimited in Columbus, a practice management firm which assists physicians with employee recruitment and management.

"Make it an appointment, a regular time each month when you sit down with your employees and discuss problems and suggestions," she says. Staff meetings can be used to review the past month's activities, along with those of the coming month. It is also an opportunity for you to compliment staff members for work well done. "It's a way to build communication and team spirit," Jesseph says.

Another approach to a disorganized office is to sit down and take an objective look at all of the tasks that need to be performed in your office; you may want to hire professional help to assist you in undertaking this task.

"We go in and evaluate a daily routine," says Jesseph, "the number of phone calls that come in, the number of patients seen, and the amount of work that is generated by each patient — charts, lab tests, referrals, treatments, insurance claims and so on. Then we determine how many people it should take to get this volume of work done — the number of hands the work necessitates."

At this point, a job description should be written for each position, giving clear direction on what every job entails. You may, however, want to build some flexibility into these job descriptions, such as "performs other tasks as requested by the physician," so that employees will understand their duties may change under your direction, Kulwin suggests.

It is also wise at this point to develop a policies and procedures manual, if you don't already have one. This should cover routine matters like vacations, holidays, sick leave and personal days, along with your policies regarding performance evaluations, salary increases, probationary periods and termination.

Having job descriptions and office procedures and policies in writing will help clear misunderstandings and insure that all employees are being treated fairly and equally. "It lets them know what you expect of them and what they can expect of you," Jesseph says. "With everything down on paper, it takes the burden off the doctor and the office manager and it puts it on the book. It allows you to say, 'I'm sorry, but this is our policy.' "

You may feel you are getting by adequately with a single receptionist who answers your phone, greets your patients and schedules your appointments. However, if incoming phone calls are constantly being placed on hold or transferred to your answering service, you could be losing a lot of business.

At this time you can begin to evaluate just how many employees you need to run your office effectively and efficiently. Other factors to be considered are the size of your patient load, the number of physicians in your practice, your specialty, and the amount of work you choose to handle in-house. For example, if you utilize an outside billing service or if you routinely send patients outside for lab tests, you won't need as many people as if you handle these tasks yourself.

It is also wise to look at the efficiency with which your work load is being handled. You may feel you are getting by adequately with a single receptionist who answers your phone, greets your patients and schedules your appointments. However, if incoming phone calls are constantly being placed on hold or transferred to your answering service, you could be losing a lot of business, Jesseph warns.

Likewise, if your work day is constantly being interrupted by phone calls from your patients who have medical concerns, it may be time you considered hiring some additional clinical help to answer their questions.

Finally, you should check with your accountant to determine the number of personnel your practice can afford to hire and the salary and benefits packages you are capable of offering them.

Once you've determined the staff you need, how do you go about finding, hiring and keeping quality personnel?

"First, sit down and compose an ad that specifically relates to the job description for the position you want to fill," Kulwin suggests. "Don't make it too general, or you'll get too large a response," he adds. On the other hand, don't be too idealistic, or you're likely to scare away some good candidates.

Place the ad in an area that is likely to attract the type of person you are looking for: community colleges that offer medical assistants programs, vocational schools with clerical programs, internship programs and even hospitals — although a good hospital staff member doesn't automatically make a good office staff member, Kulwin warns.

You might also want to ask colleagues and staff members for suggestions, although hiring friends, spouses and other relatives is not

always wise. "They may expect special treatment," Kulwin explains, "and other employees may resent them." Also, if things don't work out, it may be difficult to fire them without a lot of hard feelings.

Jesseph has found placing ads in the Sunday newspaper classified ad section to be effective, although you may be swamped with inquiries from people not really qualified for the job. She suggests asking potential candidates to call during specified hours so that they can quickly be screened for the minimum qualifications.

If you choose to use the services of an employment agency, "Make sure you deal with a reputable one," Kulwin says. And avoid those that have a reputation for sending out as many applicants as they can, regardless of their qualifications.

Finally, don't overlook the possibility of hiring good, part-time help. Senior citizens looking for half-day work or housewives willing to come in evenings or weekends can provide you with cost-efficient labor and take a substantial load off your full-time office staff.

Once you have a promising list of candidates, ask them to send you a resume, or have them complete an application form which asks for information on previous employment, salary expectations, references, and educational background. Kulwin suggests the standard "Application for Employment" form developed by the AMA, which has been carefully designed with current Equal Employment Opportunity regulations in mind.

Screen the completed application forms or resumes for those that came closest to meeting your needs. Then schedule these candidates for interviews — no more than four a day — and set up a time you can talk comfortably and confidentially with them, such as early in the morning before the office opens.

Make sure you have read the resumes or application forms before the interview — your questions should be based on the information they contain. And to avoid legal problems, never ask questions concerning religion, race, color, age, sex, national origin or ancestry, marital status, family plans or type, and date of military discharge, Kulwin says — unless that information can be proven to be directly related to the job.

Questions concerning arrests are also forbidden, although you may inquire about a record of convictions or felonies.

Kulwin also suggests you take objective notes during an interview — covering items like reference checks, job-related experience, etc. But don't put down personal remarks that could be negatively interpreted if your records should be subpoened.

Jesseph highly recommends testing applicants for basic typing, writing

Selecting an Office Manager

From a financial standpoint, the most important person on your payroll is your office manager — that right-arm individual who takes full charge of the business side of your practice so that you can devote full time and energy to the clinical side.

In a small practice, the office manager may be your only full-time employee; in the larger office, he or she oversees the work of a number of employees and makes sure everything runs smoothly. And in the large group practice or clinic setting, an office management "team" will, no doubt, be headed by someone with advanced degrees in business and finance — someone capable of investing your earnings, as well as collecting and accounting for them.

"The office manager wears a lot of hats, from personnel manager and reimbursement specialist to public relations person and the doctor's right arm," says Tom Bishop, an office manager for a medium-sized practice in Marion, and the president-elect of the Ohio Medical Group Management Association (OMGMA).

"He or she is also the intermediary between the doctor and the patient — as well as the doctor and the employees. Disputes can be resolved by a competent business manager before they become serious."

An office manager also has to be a good communicator, Bishop continues. Therefore "people skills" — the ability to interact well with other people — are essential.

Maury Kulwin, a program administrator for the AMA, agrees. "An office manager needs good organizational skills and the ability to work with and manage other people — to diffuse conflicts and to clarify misunderstandings before they become major problems."

Other important qualifications are the ability to delegate responsibilities, to appropriately evaluate jobs, and to oversee the workload — to take overall charge of the day-to-day operations of the office. "The business manager is a 'jack of all trades' — and a 'master of all trades' as well," Kulwin says, "from insurance processing and appointment scheduling to exam room preparation and the ordering of supplies."

If you do not at the present time have someone in your office handling these kinds of responsibilities, you may want to consider hiring an office manager, particularly if you have more than two or three full-time employees and they seem to be suffering from a lack of coordination and communication.

Again, a discussion with your accountant is wise, "number one, to see if you can afford to hire an office manager," Kulwin says. "And number two, to see if you can afford *not* to hire one."

Good office managers can be found in a number of locations — the first place you may want to check is within your own staff, says Linda Jesseph, Medical Consultants Unlimited in Columbus. "First look at the people who are already working for you. Do any of them have the administrative skills needed for the job? Is there a leader? Is

continued on page 851

Choosing Your Advisers

While your attorney and your accountant are rarely full-fledged members of your office staff, they are none-the-less of critical importance to your office team — to the day-to-day operation and financial well-being of your practice. Both help to set your practice on an even keel and insure that it will stay afloat through the ups and downs of your career.

A major role of the attorney in a medical practice is to help the physician navigate his or her way through the ocean of business and legal documents that deluge every change or transaction: incorporation papers, partnership agreements, real estate contracts, employment contracts, equipment purchases or lease agreements — not to mention Medicare participation contracts, IPAs, PPOs and a whole new wave of preferred provider agreements and contract medicine.

A good business lawyer should also be able to assist you with general business planning and should be familiar with the tax laws that affect your practice. He or she should work closely with your accountant and other financial advisers, making sure that your business practices are as sound as your medical ones.

Thus, when looking for an attorney for your practice, avoid the traditional family lawyer who has spent most of his/her time with wills, divorces and domestic disputes, and look for one with a background in business. While the state does not certify lawyers in specialty areas, "attorneys do tend to specialize," says Marlene Frank, a Columbus attorney who concentrates on tax and pension work. "You need a business lawyer — not someone who is good at malpractice suits. The insurance companies provide you with those attorneys."

Accountants should be chosen with the same set of goals — to help you with the tax and business management side of your practice. "The big accounting firms generally have accountants working in three different areas: tax returns, auditing, and management information services," Frank explains. "You need tax advice and preparation services," she says, along with "management information services: advice on billing procedures, financial statements — someone who can help you set up different types of management information."

A good accountant can help you select a computer system for your office, or will help you set up a general bookkeeping program. She or he can also give you advice on numerous other practical and financial matters, from the best insurance package to select for your employees to setting up a pension plan.

Getting good professional advice, however, involves more than finding someone with the proper degrees. "You need to choose a professional you feel comfortable with — someone who is easy to understand and willing to take the time to answer your questions," says Frank.

If you are just setting up a practice and need a large amount of professional work done, Frank suggests taking bids for the total project (such as setting up a partnership), then retaining an adviser on an hourly basis.

Check with colleagues, professional organizations and associations, and friends in other professions for the names of some good advisers. And talk to several attorneys and accountants before making a final selection.

Other points to consider are:

1. If you decide to contract with a large firm for services, ask if you'll get the same professional every time, or if your work will be divided among several advisers. Will you be working with the senior members of the firm or the junior partners? And who is ultimately responsible for your account?

2. Does the adviser have some experience working with physicians? If so, ask for references. Find out how happy your colleagues are with

continued on next page

and spelling skills — and any other attributes that are related to the job.

Never hire a candidate on the first interview. First check their references, to make sure the information they have given you is accurate. Then, "ask your best candidates back for a second interview when the office is open," Kulwin suggests.

"Allow them to spend a little time in the office. See how other staff members react to them. Let them know what really goes on in your practice. Some people have a romanticized view of what goes on in a doctor's office. They should understand it's not like 'General Hospital'."

Once your new employee or employees have come on board, it is important to give them time to adapt to your office. Both Kulwin and Jesseph recommend a three-month probationary period, with a full evaluation at the end of six months.

"If things aren't working out, have a counseling session with the employee and explain your concerns," Kulwin says. "Give the person a time-line to meet your concerns. If things still don't work out, call the employee in for a second consultation and give him or her another, shorter warning period."

It is also important that you document any problems with an employee and that you ask the employee to sign these documents. "Keep a paper trail showing your concerns," Kulwin suggests. If the employee refuses to recognize the problem, ask other employees to sign as witnesses.

If you've developed a well-defined job description, screened your candidates adequately and put a great deal of thought and time into your selection of an employee, chances are termination will not be an issue. But even the employee who is meeting all of your expectations should be evaluated regularly — at least twice a year, says Jesseph. And annual raises should be awarded according to merit, not "cost of living," she says.

In order to insure your best employees will stay with you, your salary and benefits packages must be competitive with others awarded in business and industry, Jesseph points

out. Legal holidays, two weeks annual vacation, three personal days a year, seven to eight days of sick leave, and life and medical insurance policies have all become standard, she adds.

And a few extra benefits — such as a birthday holiday, an extra day off at Thanksgiving and a Christmas pay bonus — can go a long way towards building good will among your staff members, making sure employees are not only satisfied but happy with their working environment, she adds.

Allow them to spend a little time in the office. Some people have a romanticized view of what goes on in a doctor's office. They should understand it's not like "General Hospital" . . .

"Don't be penny wise and dollar foolish," Kulwin says.

"We estimate it costs around $2,300 to train and break-in a new office employee," Jesseph continues. "If you don't pay your employees a decent living wage and the benefits they need, they'll begin looking elsewhere."

And then you'll have to start the whole process all over again. **OSMA**

Susan Porter is Assistant Editor of the **Ohio State Medical Journal.**

Choosing Your Advisers

continued

his or her work.

3. Where is the adviser located? Is he or she close enough to be convenient? Will he or she come to you?

4. What exactly are the adviser's responsibilities? How involved do you want to remain in the legal and financial aspects of your practice? Does the adviser concur with your philosophy?

Once you've found the professional advisers you need and like, keep in close contact. If things don't work out, don't be afraid to terminate the relationship and find someone new.

"Attorneys tend to get very busy," says Frank, "so make your demands known to them. Don't wait for your attorney or your accountant to get in touch with you. If you have concerns or questions, keep asking." **OSMA**

—Susan Porter

Selecting an Office Manager

continued

there someone willing to take on the extra responsibilities?"

Perhaps you have an individual who looks promising, but who has no previous experience supervising people. "You may want to send them to a local university or technical college where business management courses are offered," Bishop suggests. "The advantage to promoting from within is that the person already has a total knowledge of the practice, and this can save the doctor a lot of headaches."

There are also disadvantages to promoting from within, however. A current staff member may be hesitant to supervise other co-workers, or may have a hard time delegating former responsibilities to someone else.

If there are no qualified candidates on your staff, check with colleagues for the names of some good business managers — local business colleagues and universities are also a good source.

According to Bishop, the national organization of MGMA offers a placement service and will recruit office managers for physicians. State groups, such as OMGMA, will also spread the word that positions are open, he adds.

If your practice is small, an ad in the local newspaper under a category such as "Administrative Assistant" should bring a good response, says Jesseph. However, an ad in a trade journal or magazine will be more effective for a larger practice and a nationwide search may be required to find a qualified office manager for a large organization or clinic.

The salary and benefits package you should be prepared to offer must be competitive with those paid for similar positions in business and industry. It will also depend upon the levels of experience, education and expertise you desire.

While a small office may simply require an individual with strong clerical and bookkeeping skills, the office manager of a medium-sized office should have at least some college training and personnel experience. For the large group practice, a graduate degree in business or finance should be mandatory, along with prior experience in some branch of the health care industry.

"The financial applications of a medical practice are very similar to those of industry," Bishop says. "But you also want to make sure that the person is familiar with the ins and outs of Medicare, Medicaid and other third-party payers. Reimbursement is the name of the game for the physician, today. A good office manager must have some experience in this area." **OSMA**

— Susan Porter

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PACO

Three Years Old, and Still Growing

By Karen S. Edwards

Almost three years ago, the Ohio State Medical Association (OSMA) set forth to ease some of the practice management problems that were developing at a rapid rate in physicians offices — due, in large part, to complex billing systems, and often confusing communications with third-party payers.

The result was PACO — The Physicians Administrative Corporation of Ohio — which sprang into existence in February, 1982, and has been growing both in size and responsibilities ever since.

In an April, 1982 issue of the *Ohio State Medical Journal*, an article described PACO as "the new troubleshooters," and PACO Chairman Herman Abromowitz, MD, Dayton, envisioned the company providing various programs to assist the physician in streamlining his or her business practice.

"These services might include assistance with billing procedures, tips on cutting office overhead, practice management seminars for physicians and office personnel, patient health education materials and so forth," he said in the article.

In the two years since that article was printed, PACO has, in fact, tackled many of these — and more.

"Although PACO has recently grown in other areas, we have always viewed the company as a practice management firm," says PACO President David Pennington — and there is good reason for that.

"It is a common fallacy that physicians don't take an interest in the business side of their practices," says Pennington, "but that is just not true."

No one can afford to just "practice medicine" these days.

PACO's short-term goal is to concentrate on being a leader in those areas which have been defined as necessary types of services to physicians. Long term, we will provide additional services as needs develop.

"It's simply not an economic reality anymore," says Pennington. "The practice of medicine is a business, and more and more physicians are realizing how important it is to run that business well."

One of the first services PACO offered its members was a Direct Entry (tape to tape) billing system with the Medicaid program.

"Direct entry of an insurance claim form is the most efficient method of filing a claim with a carrier because it eliminates several levels of paper handling," Dr. Abromowitz said in the 1982 *Journal* article, and that, in turn, resulted in a faster turn-around time for reimbursements.

"Our Direct Entry services have now been expanded to include both the Medicare and Blue Shield programs," says Pennington.

PACO tries to convince physicians to use electronics in the business side of their practices, "because you can't do without it anymore. We have evolved into a business which has become pretty much electronic in nature, simply because computers are so efficient," Pennington says, but he hastens to add that PACO is not out to replace all your office personnel.

"We show you how computers can help you get more from your personnel," he says.

PACO's first step in placing a computer is to perform an evaluation of the practice to determine the physician's needs.

"We find that, when left on their own, physicians have a tendency to

grossly under or overbuy computer equipment. They can spend a huge amount and still not be equipped to handle all their practice's needs," notes Pennington.

Once needs have been determined, PACO provides a site analysis, in which the best geographical location for the computer is decided, then PACO staff trains the office's personnel in the computer's use.

Computer systems range from $8,000 to $200,000 and beyond, reports Pennington, but PACO is careful to explain that the size of the computer should relate to the size of the practice.

"I'd estimate that we've placed between 50 and 60 computers in physician's offices so far," says Pennington.

But computers aren't the only things PACO is placing.

"The placement service we began in February has continued to grow," says Robert Holcomb who recently joined PACO as Executive Vice President.

"More and more physicians are asking for assistance in this area," he says — especially those physicians who are moving away from hospital practices, and into practices in large metropolitan areas.

A full report of this new service — including a description of how PACO makes a market analysis of the area — was provided in the June issue of the *Journal* ("This Town Isn't Big Enough"), but it is interesting to note that PACO is now providing its service in a three-state area: Ohio, Kentucky, and Minnesota, proving that the need for this service is one felt nationwide.

A tight marketplace also accounts for PACO's latest endeavor — establishing PPOs (Preferred Provider Organizations — PPI, private practice initiative, as PACO prefers to call them).

"We were literally asked to do this," says Pennington, who explains that a large number of physician requests spurred PACO into initiating its PPO-building program.

"So much of today's competitive environment and push to cut costs is hurting the private physician," says Pennington.

With hospitals expanding the scope of services they offer, and alternative forms of health care being developed at a rapid rate, medical care is practically being pushed out of the traditional medical community.

PPOs provide a way for the private-practicing physician to compete in this environment, says Pennington.

"A PPO is an organized program to contain costs," explains Holcomb. "They can be tailored to meet local community needs, to meet utilization review processes; they can even be structured with regard to size. They can be as large or as small as you want."

"The PPO allows the traditional doctor to maintain what he or she has in the way of a practice, and lets them compete without taking any kind of financial risk."

"The PPO allows the traditional doctor to maintain what he or she has in the way of a practice, and lets him or her compete without taking any kind of financial risk," adds Pennington.

PACO is currently involved in forming a PPO in the Steubenville area.

"We have done a market analysis there to determine what kind of market it is, how receptive it would be to a PPO, and the types of competition it would face," says Holcomb.

The next step will be to market the PPO to area employers who would, in turn, offer it to their employees as a health-care benefit. PACO would assist the employer in promoting the PPO to its employees.

"There are currently four more PPOs in the development stage," says Pennington, who believes that, with the current health care environment the way it is, PPOs will continue to be a strong growth area for PACO.

"I would say that overall PACO has achieved a 30% growth rate each year," says Pennington, and he estimates that growth will continue — in placement, PPOs, and state-of-the-art electronic equipment.

"Cost is the issue of the '80s, and it will be the issue of the '90s," predicts Pennington, and that's why the need for an efficient practice will become more important.

"If physicians can practice efficiently, they will be better able to control costs," says Pennington — and, after all, in this day and age, that's the name of the game.

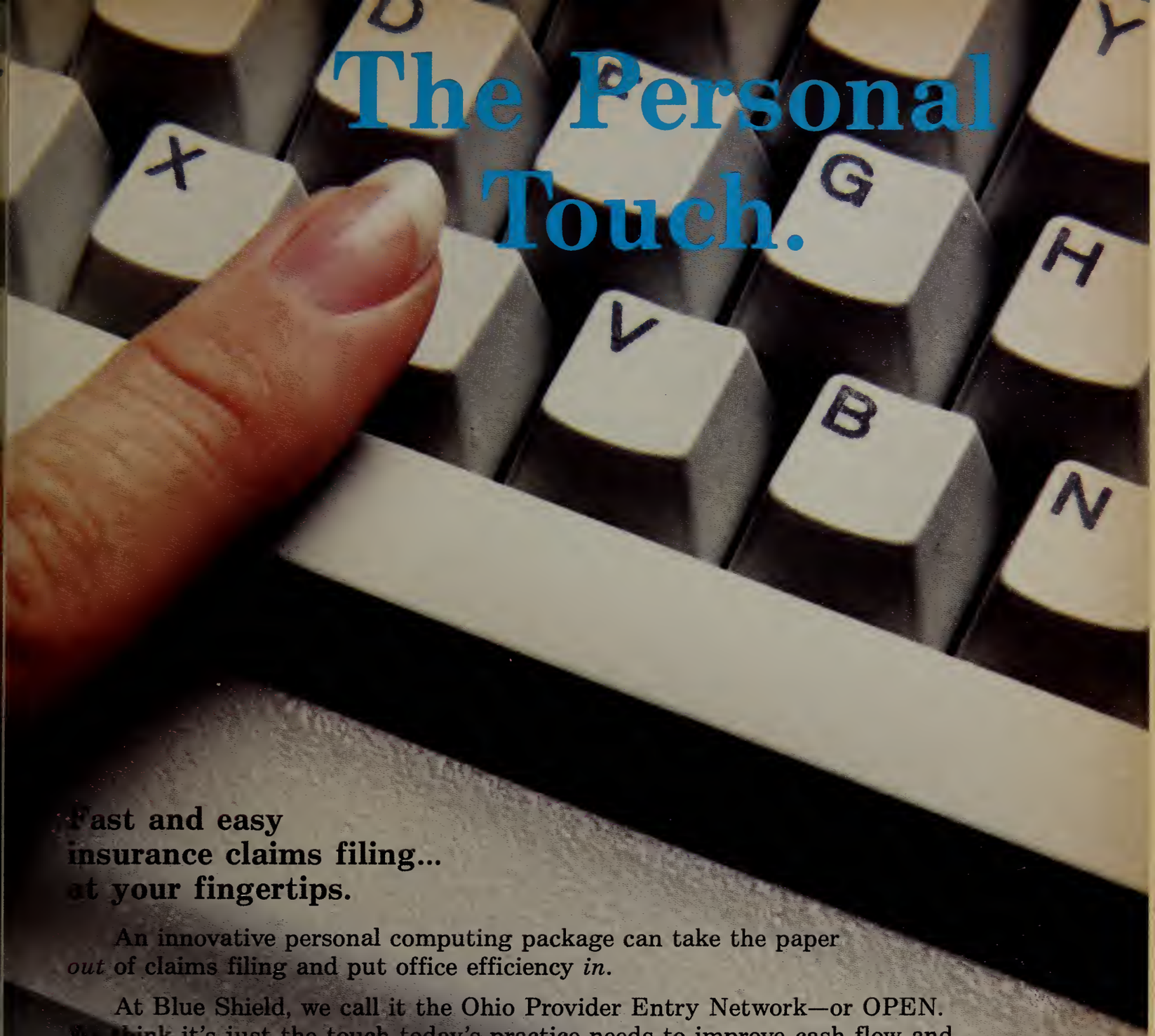
PACO's short-term goal is to concentrate on being a leader in those areas which have been defined as necessary types of services to physicians.

"Long-term, we will provide additional services as needs develop," says Pennington.

In the meantime, PACO will continue in its capacity as the OSMA's practice management arm — a company that is growing and developing as medicine continues to grow and develop, and yet a company that is never too big or too busy to listen, to answer questions, to care.

If there is an answer to the health care cost problem, perhaps it *does* lie in the area of practice management, and companies like PACO. Should that prove to be the case, members of the OSMA can consider themselves to be in good hands. **OSMA**

Karen S. Edwards is Executive Editor of the **Ohio State Medical Journal.**



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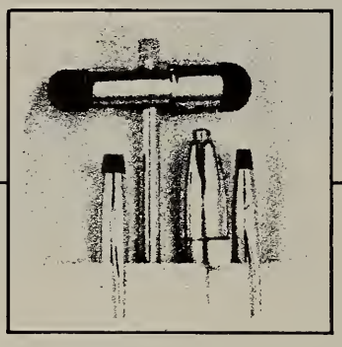
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Council Proceedings

SEPTEMBER 14-15, 1984

A regular meeting of the Council of the Ohio State Medical Association was held Friday evening, September 14 and Saturday morning, September 15, 1984, at the OSMA Headquarters Office, Columbus, Ohio.

Those present Friday evening were: A. Burton Payne, M.D., Ironton; Herman I. Abromowitz, M.D., Dayton; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; William J. Marshall, M.D., Dayton; Thomas R. Leech, M.D., Lima; Benjamin H. Reed, M.D., Wauseon; Donavin A. Baumgartner, Jr., M.D., Cleveland; J. James Anderson, M.D., Youngstown; Nermin D. Lavapies, M.D., Martins Ferry; Carl E. Spragg, M.D., New Concord; Thomas P. Price, M.D., Gallipolis; D. James Hickson, M.D., Mt. Gilead; D. Ross Irons, M.D., Bellevue; Joseph L. Kloss, M.D., Akron; J.R. Sarpa, President, Medical Student Section, Toledo; Oscar W. Clarke, M.D., Chairman, AMA Delegation, Gallipolis; David W. Pennington, President, PACO, Worthington.

Those present from the OSMA Staff were: Hart F. Page, CAE; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew, Esq.; Rebecca J. Doll; Gail E. Dodson; Robert E. Holcomb; David C. Torrens; Carol W. Mullinax; Catherine M. Costello, Esq.; Louis N. Saslaw; William E. Fry; Aristotle Hutras; Vickey McVay; Carolyn H. Towner.

Those present Saturday morning were: A. Burton Payne, M.D., Ironton; Herman I. Abromowitz, M.D., Dayton; S. Baird Pfahl, Jr., M.D., Sandusky; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; William J. Marshall, M.D., Dayton; Thomas R. Leech, M.D., Lima; Benjamin H. Reed, M.D., Wauseon; Donavin A. Baumgartner, Jr., M.D., Cleveland; J. James Anderson, M.D., Youngstown; Nermin D. Lavapies, M.D., Martins Ferry; Carl E. Spragg, M.D., New Concord; Thomas P. Price, Jr., M.D., Gallipolis; D. James Hickson, M.D., Mt. Gilead; D. Ross Irons, M.D., Bellevue; Joseph L. Kloss, M.D., Akron; J.R. Sarpa, Toledo; Oscar W. Clarke, M.D., Gallipolis; Fifi Pfahl, President, OSMA Auxiliary, Huron; Donald R. Goodwin, Senior Vice President, PICO, Pickerington; William H. Gates, M.D., Chairman, Committee on Emergency and Disaster Medical Care, OSMA, Cincinnati.

Those present from the OSMA staff Saturday morning were: Hart F. Page, CAE; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew, Esq.; Rebecca J. Doll; Gail E. Dodson; Robert E. Holcomb; David C. Torrens; Carol W. Mullinax; Catherine M. Costello, Esq., Louis N. Saslaw; Aristotle Hutras; Carol Maddy.

The meeting was called to order by Dr. Payne.

He reviewed a September 11 meeting with the Deans of the Medical Schools and indicated that further sessions will be held.

The Council convened in Executive Session.

The Council reconvened in Regular Session and voted unanimously that Herbert E. Gillen be offered the position of Executive Director-Designate.

The Council also accepted the Presidential appointment of the officers as a Transition Committee and voted to thank the current Transition Committee.

Administration

The minutes of the June 26, 1984 Conference Call and the July 28, 1984 Council Meeting *were approved.*

Executive Director's Report

The Executive Director introduced Carolyn Towner, a new OSMA legislative representative.

Resolution on Founding Date

Mr. Page presented a resolution concerning the founding date of the Association, which involves an amendment to the Constitution.

The Council voted to introduce the resolution at the May, 1985 meeting of the OSMA House of Delegates.

American Association of Medical Society Executives

The annual meeting of the American Association of Medical Society Executives, in Boston, was reviewed by Mr. Page. He stated that approximately a third of the Association members were present, and that Robert A. Lang, Ph.D., executive director of the Academy of Medicine of Cleveland, was inaugurated as president.

Physicians Insurers Association

A communication from Dr. Bradford P. Cohn, Chairman of the Membership and By-Laws Committee of Physicians Insurers Association of America, and the Executive Director's reply were reviewed by Mr. Page.

The Council indicated that Mr. Page's letter was an appropriate expression of OSMA's position.

OSMA Strategy for the Mid-Eighties

Mr. Page reviewed his memorandum to the Council, dated September 14, 1984, entitled "An OSMA Strategy for the Mid-Eighties: Recommendations."

The memorandum was received and filed.

Community Bankers Association

A letter from the Community Bankers Association of Ohio was distributed to the members of the Council.

The Council referred the communication to the Committee on State Legislation.

Ms. Doll Commended

Mr. Page announced that the September 14 meeting is Ms. Doll's last official meeting as Director of Communications and thanked her for her ten years of achievement. Ms. Doll received the standing acclamation of the Council.

Delegate to U.S. Pharmacopeial Convention

A letter from the United States Pharmacopeial Convention, Inc., requesting a delegate from the OSMA was presented. Dr. Payne announced his appointment of Ray Gifford, M.D., Cleveland.

The Council confirmed Dr. Gifford's appointment.

PACO

Mr. Pennington presented a report from Physicians' Administrative Corporation of Ohio. He indicated that a business plan and proposals for raising more capital will be available soon.

Candidates for OSMA Offices

The Executive Director presented a letter dated August 31, 1984, from the Trumbull County Medical Society, nominating Joseph Sudimack, Jr., M.D., for the office of Secretary-Treasurer of the Ohio State Medical Association.

The Executive Director presented a letter dated September 4, 1984, from the Academy of Medicine of Lima and Allen County, nominating David A. Barr, M.D., for the office of President-Elect of OSMA.

The Executive Director presented a letter dated September 12, 1984, from the Muskingum County Academy of Medicine, nominating Carl E. Spragg, M.D., for the office of President-Elect of the OSMA.

The Executive Director presented a letter dated September 13, 1984, from the Academy of Medicine of Cincinnati, nominating John E. Albers, M.D., for the office of President-Elect of the OSMA.

Financial and Membership Department

Membership statistics were presented by Mrs. Wisse and the Department report was filed.

The Treasurer's report was presented by Dr. Barr and was filed.

Committee on Auditing and Appropriations

Dr. Spragg presented the minutes of the September 14, 1984 meeting of the Committee on Auditing and Appropriations.

The Council *approved* the following recommendations of the Committee:

1. That it approve for payment the Coopers and Lybrand invoice of $5600 covering the PACO operations and financial affairs review and that the cost of future projects be monitored with appropriate controls.
2. That the costs incurred by Elford for the building expansion totalling $16,142.58 be approved for payment.
3. That the administrative staff be directed to investigate the impact of vacating space currently occupied by allied groups — i.e., Academy, Auxiliary, Specialty Societies — on current OSMA personnel space needs as well as the availability and feasibility of utilizing outside rented space.
4. That Dr. Payne pursue reinstatement of the original OSMA/PICO Professional Liability Group Plan agreement.

The report as a whole was accepted and filed.

Department of Education; Specialty Society and Meeting Management

The report of the Department of Education; Specialty Society and Meeting Management was presented in writing and was filed.

Committee on Emergency & Disaster Medical Care

Dr. Gates presented a final draft of a policy statement on "Control of Medical Emergency Services at the Scene of a Medical Emergency,"[1] developed and recommended by the OSMA Committee on Emergency and Disaster Medical Care.

The statement *was approved.*

Department of Government Relations

The report of the Department of Government Relations was filed.

Nursing Home Certification

The nursing home certification problem, involving concentration of patients in metropolitan homes, was discussed by the Council and was referred to the OSMA Committee on Geriatrics with a request for prompt study and recommendations.

Department of Development & Member Services

The report of the Department of Development & Member Services was presented in writing and was filed.

OMERF

The Ohio State Medical Education & Research Foundation report was presented by Mr. Saslaw.

Medical Student Section

Mr. Sarpa reported on work with the students and that 80% to 90% enrollment has occurred among the freshman classes of the four schools where OSMA representatives were permitted to appear.

American Medical Association

The Council endorsed the candidacy of Ray W. Gifford, M.D., Cleveland, for the American Medical Association Board of Trustees.

Dr. Clarke reported that the delegation will be discussing the possibility of joining one of the regional coalitions of delegates serving in the AMA House of Delegates.

The Council considered and approved a proposed resolution asking the AMA to help implement interprofessional education within state medical societies; cosponsor with other national associations an interprofessional conference and that the AMA recommend that the curriculum of medical schools include interprofessional courses.

Resolution on Patient Education

The Council voted to submit a resolution at the December meeting of the American Medical Association House of Delegates asking for a nationwide patient education campaign integrated with and in cooperation with the State, County and specialty medical societies.

PICO

Mr. Goodwin, reporting for Physicians Insurance Company of Ohio, announced that the Florida Department of Insurance has asked PICO to form a management company to operate the Florida Professional Liability Insurance Plan formerly sponsored by the Florida Medical Association.

Department of Health Education

The Department of Health Education report was presented in writing and was filed.

National Health Service Corps

The Council discussed the new method of assigning National Health Service Corps personnel throughout Ohio and requested the OSMA Health Manpower Committee to study and to monitor this program.

Department of Staff Counsel

Mr. Mulgrew presented the Staff Counsel report.

He announced that the Chiropractic Case involving request for staff privileges was decided by the Ohio Supreme Court. The Court held that chiropractors *do not* have the statutory right to apply for hospital privileges.

At the OMIM Advance Plan litigation, a request for a summary judgement was filed Tuesday, September 11. A decision is expected on the legality of the Advance Plan by late fall.

The Council voted to file an amicus brief in a Cleveland case involving the Ohio child abuse statutes.

Mr. Mulgrew discussed the recently enacted Medicare amendments under the Deficit Reduction Act and the proposed AMA lawsuit challenging the constitutionality of several of the provisions of the Act.

Department of State Legislation

Ms. Costello presented the Department of State Legislation report and reviewed recent meetings of the Ohio State Medical Board.

The Council voted that OSMA insist that additional nursing organizations be added to the OSMA/ONA Liaison Committee.

Ms. Towner reviewed the draft of some of the changes to the Ohio Nurse Practice Act being proposed by the Ohio Nurses Association.

Mr. Hutras discussed some of the lobbying activities concerning nursing legislation.

The report was filed.

Department of Communications

Ms. Doll yielded to Ms. Mullinax, the new director of the Department.

The demand for the marketing packet "Extra Mile" continues to increase according to Ms. Mullinax, following its mention in "Medical Economics" magazine.

A slight drop in Journal advertising was reported.

A series of media training seminars, conducted by the Department, were reviewed.

The report was filed.

Department of Marketing & Field Service

The report of the Department of Marketing & Field Service was presented in writing and was filed.

Councilor Reports

The Councilors reported on the activities in their respective districts.

Auxiliary Report

Mrs. Pfahl reported on a program to organize new auxiliaries and discussed the Auxiliary's Med Vote Program to encourage physicians and their families to register and to vote.

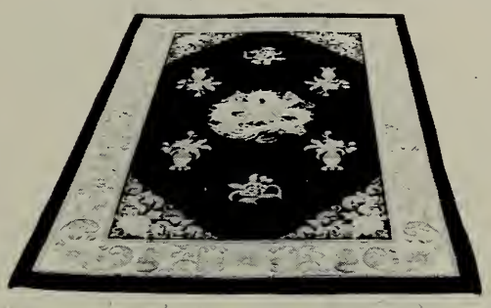
On behalf of the Auxiliary, Mrs.

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New Members

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Raymond E. Grier, East Liverpool

CRAWFORD
Michael D. Boehm, Galion

CUYAHOGA (Cleveland unless noted)
James A. Barfield
Michael R. Beer
Robert W. Beyer
Karen A. Bradley
Enrico G. Camara
Edward T. Carden
Sandra Cobb
Avrom D. Epstein
Ernesto A. Gerardo
Ronn E. Goldberg
Melettos S. Karas
Asheendiar K. Khorsandian
Kent Alan Knauer
O'Neal W. Koger, Jr.
Middleton H. Lambright
Steven M. Leber
Joseph G. Matthews
Timothy P. Obarski
John W. Parkinson
Narendra S. Patel
Parul H. Patel, Evansville
Christos J. Pitarys
Thomas Gerald Santoscoy
Warren R. Selman
Nandalike S. Shetty
James H. Silverblatt
Michael L. Spector
Kevin Larry Trangle

FRANKLIN (Columbus unless noted)
Nikola Alain
Scott Darrell Berkowitz
Maurice Mourad Douek
Mitchell Henry
Jeffrey Innes, Dublin
Duncan E. Legg
David Massie
David Charles Peter, Gahanna
Susan Stagno
Rob Steigerwalt
Matthew Morgan Tignor
Steven Yarinsky

LUCAS
William G. James, Toledo
Laurie J. Pearse, Toledo

MAHONING (Youngstown unless noted)
Rebecca S. Bailey
Andrew Bott
Sheeyip Chan
Mark B. Chaplick, Broadman
Mark J. Du Fine
Gordon L. Genskow
Kevin S. McCarragher
Michael B. Nestor
Christopher L. Southwick
Gary L. Switzer
Marc Uram
Magdy K. Yskander

MONTGOMERY (Dayton unless noted)
Arvind K. Agarwal
George R. Brown
Samuel J. Finn
Jose F. Flores, Jr.
Nidal H. Harb
Karen Jean Kovacic, Kettering
John R. Krohmer, Miamisburg
Jordan A. Moore
Magdy T. Nawar
Capt. Edward Picardi, Fairborn
Mohammed A. Shrit, West Carrollton

SUMMIT
Colin Campbell, Rootstown
J.K. Davis, Akron
Atul Goswami, Akron

Council Minutes

continued

Pfahl presented an award to Ms. Doll, expressing thanks for her assistance with the Auxiliary's Communications program.

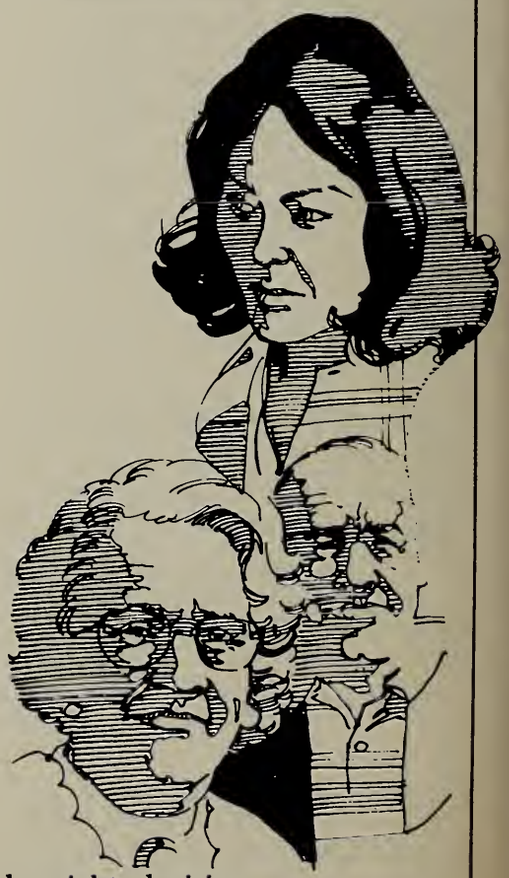
Attest
Hart F. Page
Executive Director

Cleveland Surgeon Receives Teaching Awards

EDWARD L. WILKERSON, MD, Cleveland, has been named the first recipient of the James Guy Jones Award for excellence in surgical teaching at the Case Western Reserve University School of Medicine. Dr. Wilkerson also received the Teacher of the Year Award by the transitional medical residents.

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Contraindications: Anaphylactoid reactions have occurred in individuals hypersensitive to *Motrin* Tablets or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin, iodides, or other nonsteroidal anti-inflammatory agents.

Warnings: Peptic ulceration and GI bleeding, sometimes severe, have been reported. Ulceration, perforation and bleeding may end fatally. An association has not been established. Use *Motrin* Tablets under close supervision in patients with a history of upper gastrointestinal tract disease, after consulting ADVERSE REACTIONS. In patients with active peptic ulcer and active rheumatoid arthritis, try nonulcerogenic drugs, such as gold. If *Motrin* Tablets are used, observe the patient closely for signs of ulcer perforation or GI bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity with papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin* Tablets.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* Tablets and the patient should have an ophthalmologic examination, including central visual fields and color vision testing.

Fluid retention and edema have been associated with *Motrin* Tablets; use with caution in patients with a history of cardiac decompensation or hypertension. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* Tablets safety in patients with chronic renal failure have not been done.

Motrin Tablets can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and on anticoagulant therapy.

Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, skin rash, weight gain, or edema.

Patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* Tablets are added.

The antipyretic, anti-inflammatory activity of *Motrin* Tablets may mask inflammation and fever.

As with other nonsteroidal anti-inflammatory drugs, borderline elevations of liver tests may occur in up to 15% of patients. These abnormalities may progress, may remain essentially unchanged, or may be transient with continued therapy. Meaningful elevations of SGPT or SGOT (AST) occurred in controlled clinical trials in less than 1% of patients. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with ibuprofen as with other nonsteroidal anti-inflammatory drugs. If liver disease develops or if systemic manifestations occur (e.g. eosinophilia, rash, etc.), *Motrin* should be discontinued.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.

Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy or by nursing mothers.

Adverse Reactions: The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal of which one or more occurred in 4% to 16% of the patients.

Incidence Greater than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea;* epigastric pain;* heartburn;* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness;* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence less than 1%—Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting; anaphylaxis; bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence less than 1%—Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmias (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship (PCR)"* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis. Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary.

Caution: Federal law prohibits dispensing without prescription. MED B-7-S

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Upjohn The Upjohn Company
Kalamazoo, Michigan 49001

J-4791 August, 1984

Obituaries

MILTON F. AXTHELM, MD, Caledonia; Ohio State University College of Medicine, 1931; age 82; died September 23, 1984; member OSMA and AMA.

WILLIAM E. BROWN, MD, Powell; Ohio State University College of Medicine, 1950; age 62; died September 26, 1984; member OSMA.

FRANK R. FLETCHER, MD, Westerville; University of Tennessee College of Medicine, Memphis, Tennessee, 1972; age 37; died September 20, 1984; member OSMA and AMA.

ALBERT B. HUFFER, MD, Dayton; Johns Hopkins University School of Medicine, Baltimore, Maryland, 1949; age 58; died September 24, 1984; member OSMA and AMA.

EUGENE MARTYNIUK, MD, Akron; Medisinische Fakultat der Universitat Heidelberg, Heidelberg, Germany, 1954; age 62; died July 11, 1984; member OSMA.

MARTIN MOYES, MD, Baxter, Kentucky; Medical College of Wisconsin, Milwaukee, Wisconsin, 1962; age 53; died September 12, 1984; member OSMA and AMA.

JACK F. PIETZ, MD, Toledo; University of Arkansas School of Medicine, Little Rock, Arkansas, 1959; age 58; died September 17, 1984; member OSMA and AMA.

J. EDWIN REED, MD, Cincinnati; University of Cincinnati College of Medicine, 1936; age 83; died September 17, 1984; member OSMA and AMA.

ROBERT E. SCHOTZ, MD, Lorain; Case Western Reserve University School of Medicine, 1959; age 60; died September 11, 1984; member OSMA and AMA.

FRANCIS W. SHANE, MD, Roanoke, Virginia; Ohio State University College of Medicine, 1928; age 80; died October 5, 1984; member OSMA and AMA.

LETHIA W. STARR, MD, Logan; University of Cincinnati College of Medicine, 1929; age 78; died October 7, 1984; member OSMA and AMA.

J. ALLEN WILLIAMS, MD, Cincinnati; Creighton University School of Medicine, Omaha, Nebraska, 1940; age 69; died September 22, 1984; member OSMA and AMA.

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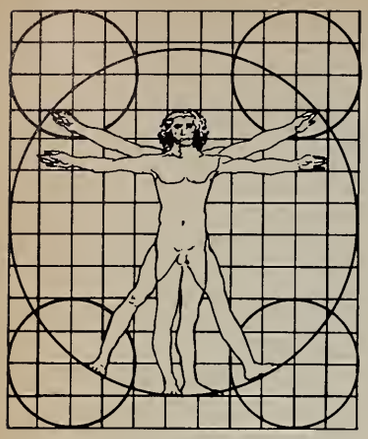
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CLINICAL & SCIENTIFIC

CLINICAL FEATURES, DIAGNOSIS AND MANAGEMENT OF INSULINOMA IN 16 CONSECUTIVE PATIENTS: COST-INEFFECTIVENESS OF NON-INVASIVE IMAGING MODALITIES

Kwame Osei, MD
James M. Falko, MD, FACP

Sixteen consecutive patients with presumed diagnosis of insulinoma were studied retrospectively over a 12-year period. Classic symptomatic fasting hypoglycemia occurred in only three of 16 (18.8%) patients. Prolonged fasting with median interval of 18 hours (range 16-20 hours) performed in 11 of 16 patients provoked hypoglycemic reactions in 90% of our patients. Simultaneous serum immunoreactive insulin (IRI) and glucose (G) ration, (IRI/G) greater than 0.3 and amended IRI/G ratio of Turner greater than 50 accurately predicted all patients (100%) with insulinoma during either overnight or prolonged fasting. Except in one patient, provocative testing with tolbutamide, leucine, or glucagon added no additional information. Selective celiac angiography was positive in eight of 13 patients (60%) with proven insulinoma. Non-invasive imaging by ultrasound, radionuclide scan and computerized axial tomographic (CAT) scan of the pancreas were also not helpful in diagnosing benign insulinoma and proved to be cost-ineffective. A higher incidence of malignant insulinoma (25%) was found in our series compared with the 10% quoted in the literature. Other epithelial malignancies (carcinoma of the colon and breast) occurred in 19% of our patients.

Introduction

INSULINOMA is an insulin secreting tumor of the beta cell of islet of Langerhans with an incidence of less than 1:100,000 population.[1-3] The first clinical case was described at the Mayo Clinic in 1927.[3] The diagnosis was made then by the presence of the Whipple's triad consisting of (a) hypoglycemia defined as serum glucose level of less than 50 mg/dl, (b) neuroglycopenic symptoms, and (c) improvement of the latter after ingestion of glucose.

Since this classic paper, the advent of sensitive radioimmunoassay (RIA) techniques for the measurement of immunoreactive insulin (IRI) has aided the diagnosis of insulinoma and other hypoglycemic syndromes. Indeed, a fourth essential component in the diagnosis of insulinoma now includes inappropriately elevated insulin levels at the time of hypoglycemia.[3-5]

In addition, various provocative tests have been employed in an attempt to make the distinction between insulinoma and other hypoglycemic syndromes.[6-9] It is now apparent that not all patients with clinical and biochemical features of insulinoma necessarily have the disease. In this regard, the diagnosis of factitious hypoglycemia or autoimmune hypoglycemic syndromes must be ruled out by a high index of suspicion, and by the measurement of insulin levels, insulin antibodies, insulin receptor antibodies,[10] C-peptide levels,[11] and plasma or urine sulfonylurea concentration.[12]

After the diagnosis of insulinoma has been made biochemically, usually radiographic imaging techniques for localization and subsequent therapy are instituted. However, there is still controversy over the imaging techniques to be used.

The purpose of this study was to review the clinical and biochemical spectrum of insulinoma diagnosed in a large teaching institution and to focus on the value of recent diagnostic modalities in the diagnosis of insulinoma. We also evaluated the cost-benefit ratio of these techniques available at our institution for the diagnosis of insulinoma.

Patients, Methods, and Materials

The medical records of 16 consecutive patients with the diagnosis of insulinoma admitted to The Ohio State University Hospital from 1970 to 1982 were thoroughly reviewed by one of us. Particular attention was paid to the clinical characteristics, laboratory data, the imaging techniques, cost-benefit ratio, and the results of therapy. We were also interested in other associated disease entities in these patients.

During the period selected for the study, our endocrine laboratory acquired a highly sensitive radioimmunoassay (RIA) technique for the measurement of serum insulin (IRI) levels. In addition, serum C-peptide RIA became available in 1979 in our laboratory. Simultaneous serum glucose and IRI levels were measured after 10-12 hours overnight fast or during prolonged fasting if symptoms did not occur by 8:00 a.m. Provocative testing with L-leucine,[7] glucagon,[8] tolbutamide[9] and five-hour glucose tolerance tests were performed in nine patients. Serum glucose levels were measured by the glucose oxidase method using the Autoanalyzer (Technicon, Inc., N.J.).

The normal range for fasting serum glucose is 65-115 mg/dl in our laboratory. Hypoglycemia was defined as a serum glucose

From the Ohio State University
College of Medicine, Division
of Endocrinology and Metabolism
Submitted April 20, 1984

level of 50 mg/dl or less. The IRI was measured by the modified double antibody RIA technique of Morgan and Lazarow[13] using Corning immunoassay kits. The sensitivity of the assay is less than 2.5 uU/ml of serum. Serum C-peptide levels were measured by the RIA technique of Kuzuya, et al.[14] to rule out factitious hypoglycemia with exogenous insulin administration. All data are expressed as mean ±SEM. Both IRI/G ratio greater than 0.3 and amended IRI/G ratio of Turner greater than 50 were used as the criteria for presumed insulinoma.[3]

Results

Demographic Features

The 16 patients included 11 females and five males with age range between 19-76 years, mean 52 ± 18 years. The mean percent ideal body weight was 108.8 ± 6% (range 68%-152%).

Clinical Presentation

Depicted in the Table are the initial presenting symptoms in our patients. Almost 94% of our patients had two or more of the following symptoms: sweating, palpitation, blurred vision, diplopia, dizziness, and generalized weakness. The duration of symptoms ranged from two months to 15 years with mean of 48 ± 2 months.

Hypoglycemic symptoms occurred at varied times and differed from patient to patient. Classic fasting hypoglycemic symptoms were documented in only three of 16 patients (18.8%) but mid- and late-afternoon hypoglycemic symptoms were common, especially three to five hours after meals. When these symptoms did occur, 81% of the patients described the classical Whipple's triad. In fact, some patients had learned to carry sugar-containing candy or sweets which alleviated their attacks promptly.

Confusion was the initial presentation in three patients. Grand mal seizure occurred in four patients. Transient electroencephalographic (EEG) abnormalities were documented in five patients. These changes disappeared after the treatment of hypoglycemic attacks except in case 7 who had recurrent seizures with a temporal lobe focus.

One patient (case 15) was three months pregnant when she presented with hypoglycemic coma at our emergency room. She was previously diagnosed as having "reactive hypoglycemia" and was treated with frequent small feedings. One other patient (case 1) was referred to us for "reactive hypoglycemia" and was subsequently found to have metastatic insulinoma.

Laboratory Features

Fasting and Prolonged Fasting: Eleven of 16 patients underwent overnight fasting. Prolonged fasting was performed only if hypoglycemic reactions did not occur after fasting 10-12 hours overnight. Simultaneous fasting serum glucose and IRI in the eleven patients are shown in Figure 1.

Eight patients had inappropriately high IRI levels compared with the corresponding serum glucose. Five patients developed fasting hypoglycemia with only three having symptoms.

Prolonged fasting up to 16-20 hours was required to induce hypoglycemic reactions in the rest of the patients except one (case 7). The latter patient (case 7) continued fasting up to 42 hours with appropriate serum glucose of 83 mg/dl and IRI of 15.5 uU/ml levels. The fast was discontinued at this point. His IRI to serum glucose (IRI/G) ratio of 0.19, and the amended IRI/G ratio of Turner of 29, were both within normal limits. He subsequently underwent tolbutamide testing which was positive. On the day of the tolbutamide testing his serum fasting glucose level was 44 mg/dl with a simultaneous IRI level of 25 uU/ml.

The IRI/G ratio greater than 0.3 and amended IRI/G ratio of Turner greater than 50 established the diagnosis in 11 out of 11 patients either after overnight fast or during the prolonged fasting. Of the remaining five patients, four had malignant insulinoma and were referred for chemotherapy and the fifth patient had bleeding colonic cancer which required emergency surgery.

Provocative Testing: Prior to 1977, provocative testing with intravenous IV tolbutamide, L-leucine and glucagon was performed in a total of nine patients. Six patients had a positive tolbutamide test characterized by persistent or sustained hypoglycemia (serum glucose less than 50 mg/dl) occurring within 30-60 minutes after tolbutamide administration. Figures 2 and 3 show the serum IRI and glucose responses in three selected patients after 1 gm IV tolbutamide administration. The highest serum IRI levels obtained in this study occurred during this test in case 13. His stimulated two-minute IRI was 695 uU/ml with the corresponding serum glucose of 50 mg/dl. The serum glucose decline to a nadir of 25 mg/dl within 30 minutes. IV glucose reversed the symptoms of hypoglycemia within 10 minutes. Case 7 had a positive tolbutamide test with serum glucose of 22 mg/dl and IRI of 10 uU/ml at 60 minutes. His stimulated IRI at 5 minutes was 320 uU/ml. Intravenous L-leucine and glucagon tests were done in three and four patients respectively and were positive in all.[3,7-9]

Oral Glucose Tolerance Test (OGTT): Five-hour oral glucose tolerance test was performed with 75 grams of glucose at our institution in six patients with variable responses. The results of five selected patients are shown in Figure 4. Four patients had asymptomatic hypoglycemia with serum glucose ranging from 18 mg/dl to 40 mg/dl at four hours which persisted through the fifth hour. Case 2 exhibited glucose intolerance after the glucose load. Fasting hypoglycemia with blunted serum glucose responses to the oral glucose load were found in cases 6 and 11.

Serum C-Peptide Levels: This peptide was measured in three patients. Two patients (cases 1 and 16) had fasting serum C-peptide levels of 5.8 ng/ml and 3.2 ng/ml with corresponding serum glucose of 40 mg/dl and 44 mg/dl, respectively. Case 15 who was three months pregnant at the time of diagnosis had fasting serum C-peptide level of 1 ng/ml with a corresponding serum glucose of 53 mg/dl and IRI of 32 uU/ml.

Results of Imaging Techniques

Selective celiac angiography was performed in 13 of 16 patients. Eight patients (60%) had detectable "tumor blush" and insulinoma was confirmed at laparotomy. Ultrasound of the abdomen was performed in six patients. Only three of six had positive results for either an intra-abdominal mass, liver metastases, or pancreatic mass. Prominence of the head of the pancreas was documented in one patient. No definite pancreatic tumor was detected on the ultrasonographic study except in one patient. This patient (case 13) had a pancreatic mass measuring 10 x 14 cm situated at the tail of the pancreas.

Two of the three patients had demonstrable liver metastases by ultrasonography of the liver. An intra-abdominal mass involving the omentum was described in one patient (case 4). High resolution computerized axial tomographic (CAT) scan of the abdomen was done in four patients. Three had definite intra-abdominal masses which were the same lesions detected by the ultrasonographic studies. Two patients (cases 4 and 13) had intra-abdominal masses in the proximity of the pancreas.

It was not possible to determine the exact origin on the CAT scan. Liver and spleen radionuclide scans were performed in seven patients. Only three were found to have hepatic lesions by this modality. The pancreatic scintigraphic scan did not detect any definite lesion in the three patients who underwent this study but had positive angiographic studies.

Operative and Histopathologic Findings: Fourteen of 16 patients underwent laparotomy. Four patients had malignant insulinoma at the time of diagnosis. Exploratory laparotomy demonstrated peri-pancreatic lymph node involvement as well as multiple metastatic lesions in the liver. This constituted 25% of our series. Nine patients (64%) had demonstrable benign tumors in the pancreas. The size of the tumors ranged from 0.8 cm to 14 cm. Five of nine patients (56%) had tumors which were less than 2 cm in size; two patients (22%), 2-10 cm and two patients (22%) had tumors greater than 10 cm in size. One patient (7%) had multiple adenomatosis with three lesions distributed in the body and tail of the pancreas. He had previously

continued

undergone subtotal parathyroidectomy for primary hyperparathyroidism (MEN I). In two patients no tumor was identified at surgery.

The tail of the pancreas constituted the commonest site for islet cell tumors (57%); body alone, two patients (13%); head alone, three patients (23%); and body and tail in one patient (7%). One patient (case 7) had distal pancreatectomy on the basis of a strong clinical and biochemical evidence of insulinoma despite negative angiographic studies and absence of palpable tumor at laparotomy. A benign tumor measuring less than 0.8 cm was found in the tail of the pancreas after serial sectioning.

One patient (case 16) presented with biochemical evidence of insulinoma. Occult blood was detected in his stool. Double contrast barium enema and colonoscopy demonstrated ascending colon carcinoma which was subsequently resected. No overt pancreatic lesion was found at laparotomy. It is still unclear whether the colonic carcinoma was producing insulin or insulin-like factors since special stains were not done to rule out this possibility on the histologic specimen.

Case 15 who was three months pregnant opted for distal pancreatectomy and suction abortion at the request of her family. Two patients (cases 6 and 14) with negative angiographic studies refused surgery, thus the sites and sizes of the tumors, if any, could not be determined.

Discussion

Insulinoma is a rare tumor of the islet of Langerhans. Therefore, the purpose of our review was to focus on the clinical and biochemical spectrum of patients with insulinoma managed in a large teaching hospital. We also reviewed the more recent diagnostic and therapeutic results as well as the cost-benefit ratio of these non-invasive imaging techniques. Over the past 12 years, we evaluated 16 patients with possible insulinoma. The incidence of islet cell tumor was less than 1:100,000 patient population admitted to the medical unit per year and is similar to the incidence previously reported in other institutions.[1-3, 5] In contrast to previous reports, 11 of 16 of our patients were within their percent ideal body weight and not obese.[2-4] Fifteen of 16 patients had intermittent hypoglycemic symptoms at variable time periods in agreement with those reported by Service, et al.[3] and Broder, et al.[15]

Although hypoglycemic symptoms occurred in almost all our patients, the classic fasting hypoglycemia with symptoms was documented in only three of 16 patients. However, 81% of our patients did describe Whipple's triad with neuroglycopenic symptoms which were relieved by glucose ingestion at some point during the day. Case 15 developed fasting hypoglycemia only when she was three months pregnant. She was found comatose one morning after omitting her breakfast. Her serum glucose was 32 mg/dl with the corresponding serum IRI level of 55 uU/ml when she was brought to our emergency room. Intravenous D50W reversed the hypoglycemic reaction promptly.

Similarly, Serrano-Rios, et al.[16] and Rubens, et al.[17] reported two patients with insulinoma complicating their pregnancies in the first trimester and both were cured by distal pancreatectomy. It should be noted that a high index of suspicion is required for the diagnosis of insulinoma in pregnant patients since their fasting serum glucose levels are lower than non-pregnant females. Furthermore abnormal IRI/G ratios have been found in normal, non-insulinoma pregnant patients.[16]

Reactive hypoglycemia was reported to be the diagnosis in each of two referred patients (cases 1 and 15) in our series. Connor, et al.[18] reported a case of an insulinoma patient who presented with purported reactive hypoglycemia as the initial presentation. However, the glucose levels after OGTT in their patient failed to rise to normal levels after a nadir at three hours and cast doubt as to the diagnosis. Thus, blunted glucose responses to a glucose load in the absence of other endocrine and gastrointestinal diseases should raise the suspicion of insulinoma (Figure 4).

Also, since the entity "reactive hypoglycemia" is still unresolved, insulinoma should be considered in all such patients by measuring simultaneous serum glucose and IRI levels. Our study confirms the great variability in both serum glucose and insulin concentrations after oral glucose load in even histologically proven insulinoma patients. In this regard, Nelson, et al.[19] monitoring the 24-hour profiles of IRI and other enteropancreatic hormones showed exaggerated IRI responses to meals in some insulinoma patients. The latter responses together with the intrinsic, pulsatile insulin secretion in insulinoma patients may partly account for the variable results of the oral glucose tolerance test as amplified by our studies (Figure 4). Thus, cautious interpretation of serum glucose responses to a glucose load is necessary in these patients.

We found prolonged fasting under carefully supervised conditions to be the most useful single diagnostic test in insulinoma patients and is in agreement with the other reported series.[2-5] In our cases, we were able to confirm the diagnosis of insulinoma in 10 of 11 (91%) patients with IRI/G ratio greater than 0.3 and amended IRI/G ratios of Turner[19] greater than 50 at the time of hypoglycemic symptoms during prolonged fasting. Symptomatic hypoglycemia occurred after 16-20 hours of prolonged fasting in all the patients studied except case 7. This predictive value is even higher than the previously reported confidence limits of 75% in 24 hours.[2,3,20]

Localization of insulinoma and selective venous sampling pre- and intra-operatively have received much attention in recent years.[2,3,21,22] Reports have appeared in the literature in which selective celiac angiography correctly identified an insulinoma in 38%-86% of patients.[3] Edis, et al.[5] reported that 30 of 34 patients with insulinoma were correctly localized before operation by angiography with adjunctive magnification, stereoscopy, and subtraction techniques.

However, the necessity for preoperative angiographic localization of insulinoma has been questoined by Daggett, et al.,[21] since nine of 18 insulinomas with positive angiographic findings in their series could be easily palpated at surgery.

Angiography was positive in 60% of our patients who had this study. Only one patient who had a negative study was found to have a small microadenoma measuring less than 0.8 cm by serial sectioning of the pancreatic specimen. In such rare patients, Turner, et al.[22] have suggested selective venous sampling from splenic and portal veins at either laparotomy or via a precutaneous transhepatic route to guide localization and resection of pancreatic tumors. However, this has also been questioned by others.[24]

Other imaging techniques such as CAT scan, ultrasonography, and radionuclide scans of pancreas adds little information to the localization of benign insulinoma which could not otherwise have been obtained by either celiac angiography or laparotomy in our series. Indeed, Dunnick, et al.[23] reported the yield of CAT scan and ultrasound in insulinoma to be 20% and 10% respectively.

The total cost of such non-invasive modalities ranges from $800-$1,000 per patient in our institution and are without any demonstrable benefit in benign tumors. However, the use of non-invasive imaging modalities is necessary for metastatic malignant insulinoma with lymph node and hepatic involvement and subsequent follow up.

The distribution of the tumors in the pancreas in our series was similar to those reported previously.[3,4,13] Benign lesions comprised 75% of our series. However, we found four of 16 patients (25%) to have malignant insulinoma which is 2 ½ times the incidence reported in the literature[1-5, 17] and may be related to the referral pattern in our hospital. Twelve patients had either a Whipple's procedure, partial or distal pancreatectomy or enucleation or benign solitary tumor depending upon the operative findings and the surgical practice of the surgeon. All the patients with benign tumors were cured after surgery.

Two patients (cases 6 and 14) who had negative angiographic studies refused surgery. They were treated medically with diazoxide and thiazide diuretics. The nature of their disease is still unclear, but they are doing well. Benign pancreatic hyperplasia,

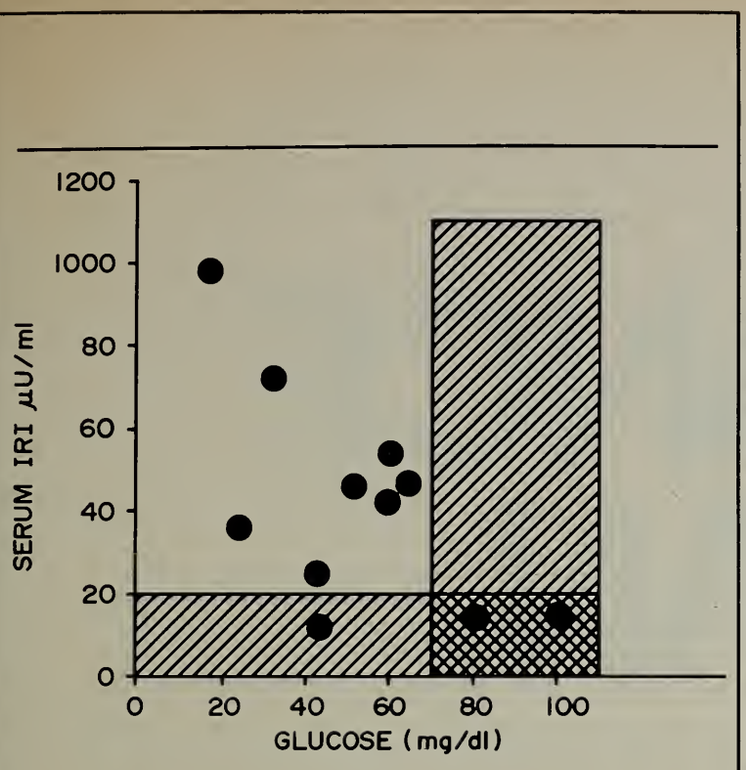


Figure 1
Simultaneous fasting serum glucose and IRI levels in eleven insulinoma patients. Cross-hatched area represents the normal range in our laboratory.

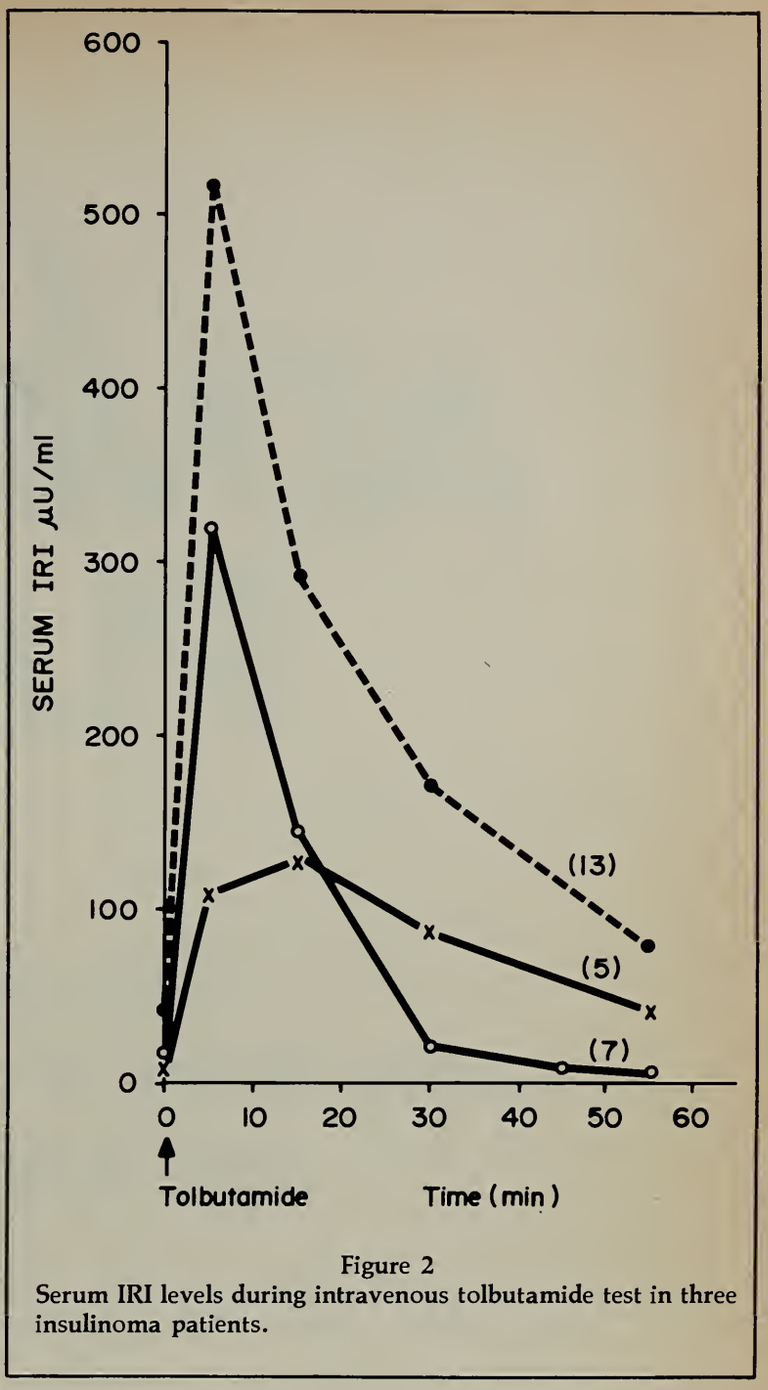


Figure 2
Serum IRI levels during intravenous tolbutamide test in three insulinoma patients.

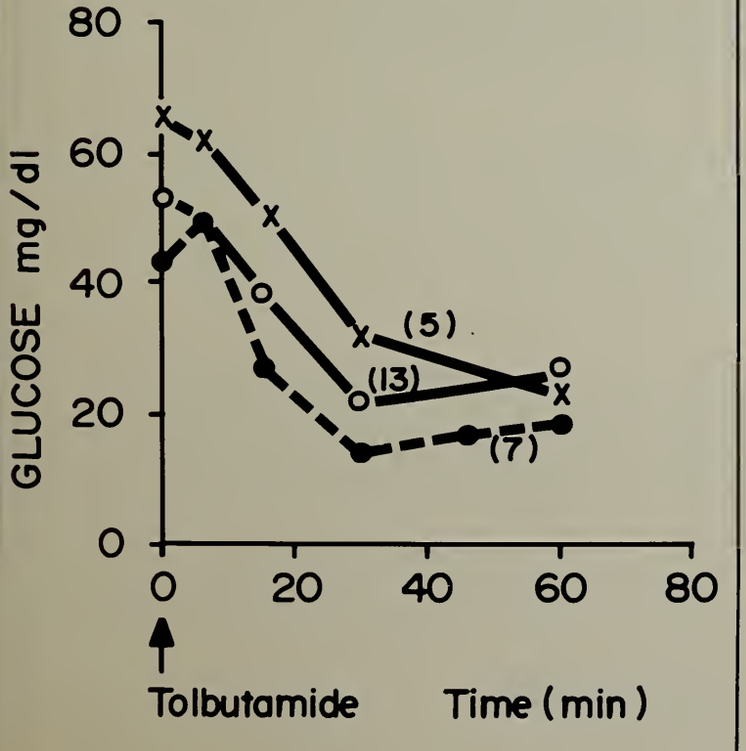


Figure 3
Serum glucose levels during intravenous tolbutamide test in three insulinoma patients.

microadenomatosis, or nesidioblastosis may be the cause of hypoglycemia in such patients.[4,24]

Chemotherapy with either streptozotocin, chlorozotocin, pentamidine[25] and 5-fluorouracil were given to patients with malignant insulinoma. This therapy did not appear to improve their clinical course in our small series. However, Broder, et al.[26] have reported in a larger series of 52 patients, increased survival rates and median survival interval in patients who showed response to streptozotocin therapy.

Of interest was the other neoplastic diseases found in some of our patients. One patient (case 10) had multiple endocrine neoplasia (MEN 1) with insulinoma and primary hyperparathyroidism. This patient developed adenocarcinoma of the breast 10 years later.

Metastatic adenocarcinoma of the colon in association with malignant insulinoma was found in one other patient (case 9). In addition, case 16 had adenocarcinoma of ascending colon.

This represents an incidence of 19% of other associated epithelial malignancies in our insulinoma patients. Whether this represents a mere coincidence or is an indication that insulinoma patients do have a higher propensity to develop neoplasia similar to familial cancer syndrome is unclear.

In conclusion, insulinoma remains a rare tumor. Prolonged fasting with simultaneous measurements of serum glucose and IRI serves as the most important single diagnostic test to estab-

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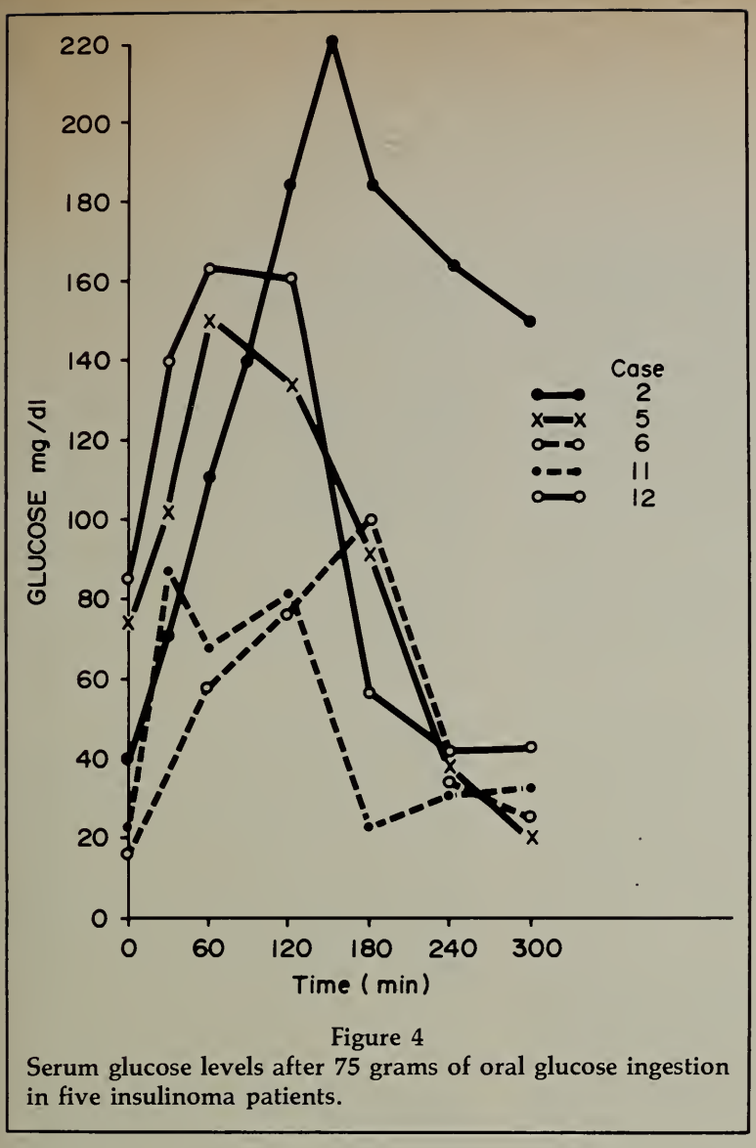


Figure 4
Serum glucose levels after 75 grams of oral glucose ingestion in five insulinoma patients.

TABLE
Symptoms In 16 Insulinoma Patients

Symptoms	% of Patients
Two or more of the following: diplopia, blurring vision, sweating, palpitation, weakness, dizzy spells	94 (15/16)
Confusion	19 (3/16)
Syncope, coma	56 (9/16)
Convulsions	25 (4/16)
Relieved by food	81 (13/16)

lish the diagnosis of insulinoma.

Non-invasive imaging modalities such as ultrasonography, CAT, and radionuclide scans of the abdomen were not helpful and indeed, cost-ineffective. Selective celiac angiography accurately detected insulinoma in 60% of our patients, but its role is still debatable.

Complete resection of benign tumor rendered permanent cure in all the patients. Other epithelial malignancies occurred with increased frequency in our insulinoma patients. The significance of this association is yet to be determined.

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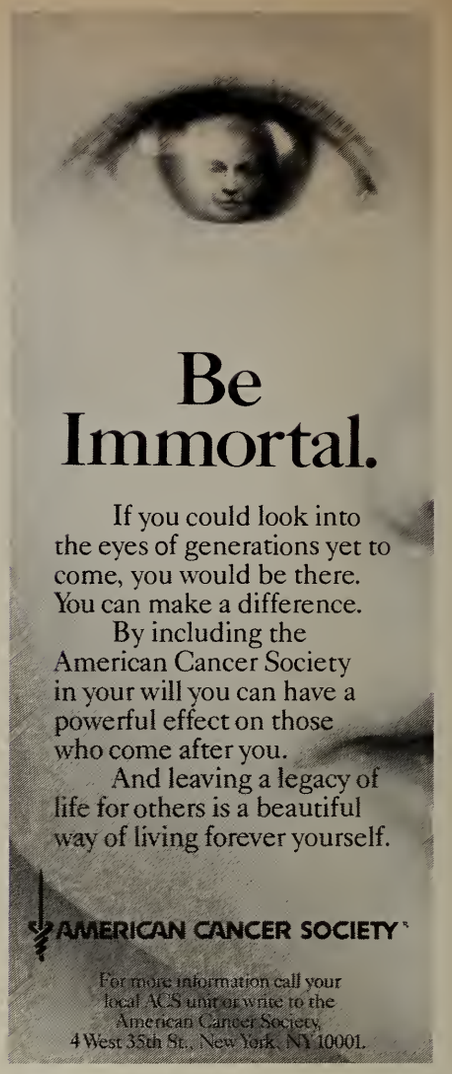
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Colleagues In The News

Edited by Doug Evans

JOHN D. BULLOCK, MD, Dayton, has been named chairman of the Department of Ophthalmology at the Wright State University School of Medicine.

PETER COHN, MD, Cleveland, has been nominated for an initial appointment, and **SIDNEY LODE, MD,** Cleveland, has been nominated for a reappointment to a three-year term on the Suburban Community Hospital Board of Trustees.

NOBEL O. FOWLER, MD, Cincinnati, has been named Medical Researcher of the Year by the Greater Cincinnati Coalition of People with Disabilities. Dr. Fowler, director of cardiology at the University of Cincinnati College of Medicine, was recognized for his contribution to understanding the cause, progression and treatment of disabling heart disease.

RAY W. GIFFORD, MD, Cleveland, has been appointed chairman of the Nominating Committee for the Officers and Trustees of the United States Pharmacopeial Convention. Dr. Gifford and his committee will select nominees for the office of president, vice president, treasurer and board of trustees for election during the Pharmacopeial Convention which meets in March, 1985.

HERMAN K. HELLERSTEIN, MD, Cleveland, has received the 1984 Mount Sinai Medical Center's Saltzman Award for his outstanding contribution to health care interests in the community.

BARTH HOOGSTRATEN, MD, Cincinnati, was recently invited to East Berlin to participate on a blue-ribbon committee of the International Union Against Cancer. The committee is studying how survival of cancer can be bettered globally, and particularly how successes in developed countries like the United States can be extended to underdeveloped countries.

WILLIAM INGLIS, MD, Columbus, has been elected to the board of trustees of the Washington and Jefferson College in Washington, Pennsylvania.

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